CCME

2022 External Quality Review

ABSOLUTE TOTAL CARE

Submitted: March 2, 2023

Prepared on behalf of the
South Carolina Department
of Health and Human Services

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2022 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Absolute Total Care (ATC) since the 2021 Annual Review.

The goals and objectives of the review are to:

- Determine if ATC is following service delivery requirements as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2021 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review included a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of satisfaction surveys.

Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub-contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess ATC's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration:

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

ATC reviews policies and procedures annually and houses policies on the RSA Archer platform for employee access. The Centene Corporation (CNC) Policy Management Manual and Policy CC.COMP.22, Policy Management, provide guidance for the development, review, approval, and maintenance of policies. The Organizational Chart clearly identifies the key personnel and other positions needed to ensure that all health care products and services required by SCDHHS are provided to members.

The 2022 Compliance Plan Matrix and Attachments provide details about ATC's compliance program and applicable federal and state laws, regulations, accreditation standards, and contractual obligations. The Business Ethics and Code of Conduct describes ATC's expectations for conducting business in accordance with the standards and rules of ethical business conduct and applicable laws and regulations. Comprehensive compliance training and education is overseen by the Compliance Department as part of the new hire and annual training.

The Compliance Officer's roles and responsibilities, as well as those of the Compliance Committee, include oversight and guidance in adopting and implementing an effective Compliance Program. Lines of communication are described in the Employee Handbook. Information is exchanged in ways to maintain openness for employees.

Confidentiality is clearly and consistently addressed in Policy CC.COMP.PRVC.01, Privacy Program Description, the Centene Employee Handbook, and in the Compliance Plan Matrix. The Compliance Department conducts trainings for new employees and annually, thereafter covering Centene's expectations regarding confidentiality and the handling of Protected Health Information.

ATC's Information Systems Capabilities Assessment (ISCA) document indicates the MCO is capable of meeting SCDHHS' contract requirements. The organization regularly reviews and updates the policies used to maintain data and system security. Internal audits are

regularly conducted to ensure requirements are being met. ATC's disaster recovery (DR) plan adheres to and surpasses industry best practices, as confirmed by the organization's DR test results.

Provider Services:

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Credentialing processes and requirements are addressed in the Centene Corporation Credentialing Program Description and related policies. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. CCME noted that the timeframe for processing organizational credentialing applications was not addressed in policy.

The Credentialing Committee is a subcommittee of the health plan's Quality Improvement Committee (QIC), which has authority over the Credentialing Program. The committee chaired by the Medical Director and meets monthly. CCME noted that one external practitioner who was a voting member of the Credentialing Committee was not a contracted, network practitioner. During onsite discussion of this finding, ATC staff reported that non-participating providers may serve as Credentialing Committee members. This is out of compliance with the Credentialing Committee Charter, which states the committee composition includes network practitioners, and with Policy CC.CRED.03, Credentialing Committee, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers." Additionally, documentation of Credentialing Committee member attendance was unclear on the Credentialing Committee minutes due to lack of a key defining the indicators used to document attendance.

No issues were identified in the review of initial practitioner credentialing and recredentialing files. One initial credentialing file for a rural health clinic did not include a South Carolina Department of Health and Environmental Control license, which was required by health plan policy. Credentialing staff conduct ongoing monitoring of network providers for sanctions and exclusions as required.

Appropriate processes are in place for routine monitoring and evaluation of the adequacy of ATC's provider network. When evaluating the network, ATC analyzes deficiencies, identifies barriers and opportunities for improvement, and prioritizes actions to address network gaps. The current review revealed ATC corrected a previously identified issue related to omission of a SCDHHS required Status 1 provider type from Geo Access mapping. ATC maintains a web-based Provider Directory that includes all required elements.

To evaluate the accuracy of provider contact information, CCME conducted a provider access study as part of the annual EQR for ATC. This study focused on primary care providers in ATC's network. From a list of current providers given to CCME by ATC, a population of 2,291 unique PCPs was identified and a sample of 190 providers was randomly selected for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. The successful answer rate for the provider access study was 61%, which was unchanged from the previous year's study. CCME encourages ATC to continue current interventions and to seek additional ways to improve successful contact rates for future provider access call studies.

ATC conducts initial provider orientation and education for newly contracted providers. Ongoing education is provided through regular meetings, regional provider training sessions, newsletters, ATC's website, etc. The Provider Manual is an additional resource for providers to understand health plan operations and requirements. Provider education includes medical record documentation and maintenance requirements, and ATC evaluates provider compliance with the standards through annual medical record audits. Processes are in place for continued review and actions for providers who do not meet performance standards related to medical record documentation. For the 2021 Medica Record Audit, the overall score was 96.4% with no practitioners scoring below the established benchmark. ATC also educates providers about cultural competency and provides additional online resources for this topic.

Member Services:

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Member Rights and Responsibilities are clearly and consistently outlined in the Member Welcome Packet, the Member Handbook, on ATC's website, and in Policy SC.MBRS.25, Member Rights and Responsibilities.

New Member Welcome Letter are mailed within three (3) days of receipt of the member listing. The benefits grids in the Member Handbook, Provider Manual, and on ATC's website outline services that require prior authorization, required co-payments, and any coverage limitations. Information about obtaining medications and medical equipment is clear. Members have access to the nurse advice line 24-hours a day, seven days a week. Information and instructions regarding family planning, women's services, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are available along with specific resources.

The member enrollment process begins by selecting a Primary Care Provider. If the member does not select a provider, one will be assigned from the provider pool based on the member's zip code. Disenrollment is described in the Member Handbook. All member requests for disenrollment are referred to SCDHHS or its designee.

Member satisfaction survey validation for ATC was performed based on the CMS Survey Validation Protocol. ATC contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct the adult and child satisfaction surveys. CCME found ATC met all validation requirements for the surveys. Results of the CAHPS surveys were reported and discussed during the August 2022 QIC meeting.

Policy SC.MM.11, Member Grievances, the Member Handbook, and ATC's website define grievance terminology, describe who can file a grievance, and provide instructions for filing a grievance and obtaining an authorized representative. Appropriate timeframes for grievance acknowledgement, extensions, and resolutions were outlined in the policy. ATC tracks and monitors member grievance data quarterly, and member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. The grievance file review found that timeliness standards were met.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

ATC provided the 2022 Quality Improvement Program Description for this EQR. This program description provides an overview of the Quality Improvement (QI) Program that ATC has established to improve the quality of care delivered to their members. The QI Program Description included the program's structure, goals, scope, and methodology.

Annually, ATC develops a work plan to help manage workflow, assign tasks, and track various components of the QI Program. The 2021 and 2022 work plans included the scope, activity description and objective, responsible party, timeline, and status of each activity. During the previous EQR, CCME recommended that ATC include the oversight monitoring of all functions performed by a delegated entity in the QI work plan. ATC included this recommendation in the QI work plan and added the oversight monitoring of the delegated entities.

ATC's Board of Directors delegates the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC is the senior management lead committee responsible for reporting the program's activities, findings, recommendations, actions, and results to the Board at least annually. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved. For this EQR, minutes were provided for meetings held from December 2021 through December 2022.

ATC's network providers receive feedback regarding their performance data through Provider Analytics, Interpreta, and a Physician Report Card. Provider Analytics is a quality, cost, and utilization tool designed to support providers who participate in a value-based program. This tool helps providers identify where to focus clinical efforts.

Interpreta is an analytic tool available to providers for generating member care gap reports. ATC also generates a Physician Report Card annually and shares the results with high-volume pediatricians. The report card is based on specific HEDIS measures and compares their rates with ATC's overall health plan rates. The current provider performance metrics are Well Child visits in the first 15 months of life, Well Child visits for ages 15 to 30 months, and Child and Adolescent Well Care visits.

Annually, ATC assesses the effectiveness of the QI Program and documents the assessment in the QI Program Evaluation. The 2021 Quality Improvement Program Evaluation was reviewed for this EQR. This program evaluation included the results of activities and studies underway or completed in 2021. A barrier analysis and any recommendations to overcome those barriers for 2022 were also included. The evaluation was submitted to the QIC in May 2022 and approved with no further recommendations.

CCME conducted a validation review of HEDIS measures following the CMS protocol for validating performance measures. This process assessed the production of these measures by the health plan to confirm the reported information was valid. The performance measure validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures were compared for the current review year (MY 2021) to the previous year (MY 2020) and the changes from 2020 to 2021 are reported in the Quality Improvement section of this report. A substantial increase or decrease is a change in rate greater than 10%. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the changes in the HEDIS measures. There were no rates that showed a substantial decrease.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	79.07%	10.18%

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validating Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

ATC submitted two PIPs for validation. Topics for the PIPs included Adult Access to Preventive Health Care and Hospital Readmissions. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions is included.

Table 2: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The baseline rate was CY2020 with a rate of 77.28%. The rate improved at remeasurement 1 (CY2021) to 78.18%. The goal is 81.97%.	
Previous Validation Score	**Current Validation Score**
Not submitted	80/80=100% High Confidence in Reported Results
Interventions	
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • ATC will utilize a vendor, Eliza, to supplement outreach by the Quality department staff to assist with scheduling appointments. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. • Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.	

Table 3: Hospital Readmissions PIP

Hospital Readmissions
The Readmissions PIP aims to reduce annual rate of readmissions within 30 days for 18–64-year-old patients. The baseline rate was 18%, which was reduced to 16.2%, and further reduced to 15.5% for remeasurement 2 (ending June 2022). The goal was to reduce the rate to 15.5% and the goal was therefore met.

Hospital Readmissions	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists members with scheduling appointments within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. Quarterly meetings with managers and the TOC team to discuss the TOC process. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • Members at risk for readmission based on most frequently admitted diagnosis are referred to the Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management. • Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meets quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.	

Utilization Management:

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment of ATC's Utilization Management (UM) Program included the program description, pharmacy description, relevant policies, clinical determination process, Member Handbook, Provider Manual, and review of a sample of approval, denial, appeal, and care management files.

ATC's Utilization Management Program Description outlines staff responsibilities, the program's scope, and objectives for physical health, pharmacy, and behavioral health services. Clinical reviews are conducted by actively licensed health care professionals who have access to licensed clinical medical directors if a Level II medical necessity review is needed. Guidelines and evidenced based clinical criteria are used to render clinical determinations. The approval files reviewed during this EQR reflected use of

appropriate criteria when making clinical determinations. Additionally, the determinations were completed within appropriate contractual guidelines for standard and expedited requests.

Overall, UM denial files reflected requests for additional clinical information when needed prior to making an adverse benefit determination and prompt communication of the adverse benefit determination to the member. However, for one file, the additional information was requested by the UM reviewer after completion of the review decision. For two denial files, the adverse benefit determination notices incorrectly informed the member that a written appeal is required within 14 days of an oral appeal request. ATC staff reported that they had already identified this as a concern and described steps implemented to alleviate this issue.

A descriptive overview of ATC's Care Management Programs is outlined in various policies and in the Care Management Program Description. ATC members are referred for care management services through various sources. Within the program, the team provides an integrated approach to manage the member's needs. The review of care management files reflected care management activities are conducted as required.

ATC's appeal process is included in the program description, relevant policies, Member Handbook, and Provider Manual. Review of a sample of appeal files reflected that the appeal guidelines and processes were followed according to contractual standards.

Delegation:

42 CFR § 438.230 and 42 CFR § 457.1233(b)

ATC reported delegation agreements with 25 entities. Policies define processes and requirements for pre-delegation assessment of potential delegates, execution of written delegation agreements, and ongoing monitoring of approved delegates. The policies note that ATC retains accountability for delegated services and monitors delegate performance through routine delegate reporting and at least annual formal evaluations.

CCME reviewed oversight documentation submitted by ATC and found that annual evaluation documentation was not submitted for one delegate. Documentation of annual oversight for the remaining delegates included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.

During onsite discussion, it was reported that results of the oversight activities for credentialing delegates are reported to the Credentialing Committee. Further, the 2021 QI Program Evaluation indicates that for all Credentialing delegates, the Credentialing Committee reviewed the results of credentialing delegate audits during the February 8, 2022, meeting. However, the submitted Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight.

State Mandated Services:

42 CFR § Part 441, Subpart B

ATC assesses provider compliance with administration of recommended immunizations and the provision of required EPSDT services through annual medical record compliance audits and by monitoring HEDIS reporting measures. ATC routinely disseminates lists of noncompliant members and member with gaps in care to PCPs, and educates providers about EPSDT requirements and recommended immunizations in a variety of ways, including new provider orientation, the Provider Manual, the website, newsletters, etc.

Follow-Up 2021 EQR Deficiencies

For the previous EQR, two standards were scored as "Partially Met" and two standards were scored as "Not Met." The following is a high-level summary of those deficiencies:

- The Geo Access mapping did not include results for all SCDHHS-designated Status 1 provider types. This was a repeat finding from the 2020 EQR.
- For the Telephone Provider Access Study conducted by CCME, had a decrease in successful calls at 61%, representing a statistically significant decrease of 12%.
- Negative changes to the Preferred Drug List were not posted to ATC's website at least 30 days in advance of the effective date.
- Deficiencies identified during the 2020 EQR were not corrected.

After the 2021 EQR, ATC addressed these deficiencies and submitted a Quality Improvement Plan (QIP) on April 7, 2022. CCME reviewed and accepted this plan on April 8, 2022. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies. Findings of the current EQR confirmed ATC corrected all issues identified during the previous EQR.

Conclusions

Overall, ATC met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of ATC's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	8	8	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	38	97%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	1	50%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	14	14	100%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

As noted in the table above:

- For Provider Selection, the identified issue was related to including non-participating providers to serve as voting members of the Credentialing Committee. This is not compliant with health plan policy or the Credentialing Committee Charter.
- For Sub-contractual Relationships and Delegation, annual oversight documentation was not provided for one delegate, and Credentialing Committee involvement in oversight of credentialing delegates was not apparent.

Table 5: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review. For 2022, 213 out of 215 standards received a score of "Met." There were two standards scored as "Partially Met" and no standards received a "Not Met" score.

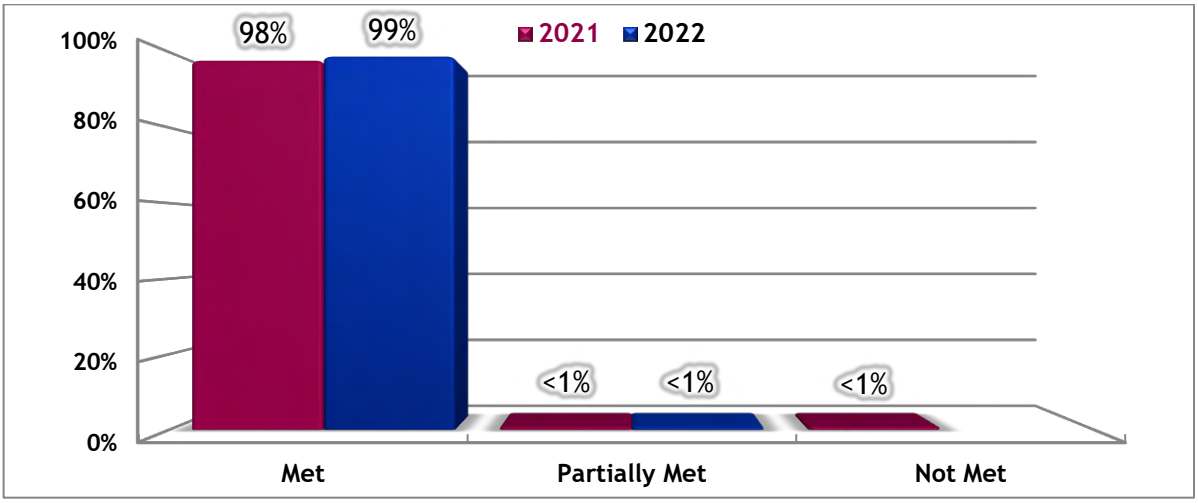
Table 5: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	40	0	0	0	0	40	100%
2022	40	0	0	0	0	40	100%
Provider Services							
2021	74	1	1	0	0	76	97%
2022	75	1	0	0	0	76	99%
Member Services							
2021	33	0	0	0	0	33	100%
2022	33	0	0	0	0	33	100%
Quality Improvement							
2021	14	0	0	0	0	14	100%
2022	14	0	0	0	0	14	100%
Utilization							
2021	44	1	0	0	0	45	98%
2022	46	0	0	0	0	46	100%
Delegation							
2021	2	0	0	0	0	2	100%
2022	1	1	0	0	0	2	50%
State Mandated Services							
2021	3	0	1	0	0	4	75%
2022	4	0	0	0	0	4	100%
Totals							
2021	**210**	**2**	**2**	**0**	**0**	**214**	**98.13%**
2022	**213**	**2**	**0**	**0**	**0**	**215**	**99.07%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

The 2022 Annual EQR shows that ATC achieved "Met" scores for 99.07% of the standards reviewed. As the following chart indicates, 0.93% of the standards were scored as "Partially Met," and there were no standards scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2021 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Overall Strengths, Weaknesses, Recommendations, and Quality Improvements

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

Table 6: Evaluation of Quality

Strengths Related to Quality
• Confidentiality is clearly and consistently addressed in Policy CC. COMP.PRVC.01, Privacy Program Description, the Employee Handbook, and in the Compliance Plan Matrix.
• Policy CC.COMP.16 Fraud, Waste, and Abuse Plan, provides detailed processes for ATC's data review, auding, and monitoring procedures.
• Practitioner credentialing and recredentialing files were fully compliant with all requirements.
• ATC's website provides cultural competency information, including the 2022 CCLAS Program Description, an Americans with Disabilities Act (ADA) – Disability Awareness Quick Reference Guide, a Cultural Competency Quick Reference Guide, and "A Physician's Practical Guide to Culturally Competent Care."
• New provider education is conducted within 30 business days of the provider's contract effective date. Ongoing education is accomplished through regularly scheduled meetings for practitioners and quarterly Joint Operations Committee meetings for facilities. In addition, updates are provided through quarterly regional provider training sessions, Provider Manual Updates, newsletters, the website, etc.

Strengths Related to Quality
• Appropriate processes are in place for review, adoption, and ongoing updates for Preventive Health and Clinical Practice Guidelines. The guidelines are disseminated to providers and others through various forums. • Provider compliance with medical record documentation standards is assessed through annual medical record audits. Results are used to identify opportunities for improvement. • Fraud and abuse are defined in the Member Handbook and on the website. Examples and instructions for members to anonymously report fraud and abuse to ATC, and to SCDHHS' Division of Program Integrity are provided. • ATC's QI Program Description and Program Evaluation was detailed and included all required elements. • The Persistence of Beta Blocker Treatment After a heart Attack HEDIS rate showed a 10.18% increase. • PIPs were based on analysis of comprehensive aspects of member needs and services, and rationale for each topic was documented. • Both PIPs met the validation requirements and received validation scores within the High Confidence Range. • The remeasurement rates for both PIPS showed an improvement in the adult preventative care rate and improvements in the hospital readmission rate. • ATC's network providers receive feedback regarding their performance data through Provider Analytics, Interpreta, and a Physician Report Card. • The overall result of the Medical IRR testing domains generated an average score of 94%, and 98% for the Behavioral Health IRR testing domains. These scores exceeded the goal of 90%. • Policies thoroughly document delegation processes and requirements. • Annual oversight documentation included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions. • ATC routinely evaluates provider compliance with recommended immunizations and required EPSDT services. • ATC corrected all deficiencies identified during the previous EQR.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The Credentialing Committee charter found on page 13 of the 2022 Quality Program Description states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider. This is not compliant with Policy CC.CRED.03, Credentialing Committee, page three, footnote number five, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers."	• Quality Improvement Plan: To comply with requirements of Policy CC.CRED.03, Credentialing Committee, replace the non-participating practitioner member of the Credentialing Committee with a participating network practitioner.
• Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational	• Recommendation: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers, and to

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
providers. Also, this policy does not address circumstances under which an organizational provider may request reconsideration of a denial of credentialing into the network.	include information about the availability for reconsideration of a denial of a credentialing application.
• Documentation of attendance of Credentialing Committee members at committee meetings was unclear.	• Recommendation: Add a key to the Credentialing Committee Minutes to define the indicators used to indicate attendance. Ensure former committee members are designated as such on the Credentialing Committee minutes.
• One file for a Rural Health Clinic (RHC) did not include a DHEC license. A copy of this RHC's DHEC license was requested, and after the onsite, ATC responded that the Policy and Procedure Guide for Managed Care Organizations, Section 2.7, has been revised to remove the requirement for Rural Health Clinics to be surveyed and licensed by DHEC. This requirement, however, is still noted in ATC's Policy CC.CRED.09, Attachment M, item 10, which states, "Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS."	• Recommendation: Revise Policy CC.CRED.09, Attachment M, to remove the requirement that RHCs must be surveyed and licensed by DHEC if the plan is not operating under this requirement.
• In two denial files, the adverse benefit determination notices incorrectly informed the member that a written appeal is required within 14 days of an oral appeal request. This is no longer a contractual requirement.	• Recommendation: Re-educate staff regarding the new adverse benefit notifications.
• No annual oversight documentation was submitted for one delegated entity. ATC staff reported that an annual evaluation was conducted in 2022 and that the documentation would be provided, but it was not received.	• Quality Improvement Plan: Ensure annual evaluations are conducted for each delegated entity.
• Policy CC.CRED.12, Oversight of Delegated Credentialing, states information about credentialing delegation oversight is reported to the QIC and/or the Credentialing Committee, and health plan staff clarified that this information is reported to the Credentialing Committee. However, the Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight.	• Quality Improvement Plan: To comply with requirements of Policy CC.CRED.12, Oversight of Delegated Credentialing, implement actions to ensure that the QIC or Credentialing Committee reviews summaries of routine oversight meetings, evaluations of interim reporting, a summary of the annual delegation review via the Report of Delegation Oversight Activities, and reports about any ongoing corrective action plans.

Table 7: Evaluation of Timeliness

Strengths Related to Timeliness
• ATC conducts regular independent audits of system security controls. • The grievance files reviewed for this EQR met acknowledgement and resolution timeliness standards. • All approval and denial files were completed timely according to contractual guidelines.

Table 8: Evaluation of Access to Care

Strengths Related to Access to Care
• ATC conducts routine monitoring of network adequacy, including monthly monitoring of geographic access to providers and annual evaluation of appointment accessibility. In considering adequacy of the network, ATC monitors member grievances about access to providers. • ATC assesses the membership's cultural, ethnic, racial, and linguistic needs annually, collects related practitioner cultural, ethnic, racial, and linguistic data through credentialing processes, and uses results to make network adjustments as needed to ensure the needs of the membership are met. • The Network Strategy Overview document shows ATC is conducting various ongoing initiatives to expand and improve its network. • The web-based Provider Directory includes all required elements. • Information for the process to obtain a Care Manager is provided in the Member Handbook. Referrals may be made by contacting Member Services Call Center. • Within the denial files, the Member Authorization Form and Member Appeal Form were attached to the adverse benefit determination notices for member convenience. • All required core benefits are provided to members.

Weaknesses Related to Access to Care	Recommendations Related to Access to Care
• For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time. When compared to last year's results of 61%, this year's study had no change in successful calls at 61%.	• Recommendation: Continue current interventions and seek additional interventions to improve successful contact rates for Provider Access Call Studies.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On November 7, 2022, CCME sent notification to ATC that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow ATC to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from ATC and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on February 1, 2023, and February 2, 2023. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with ATC's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between ATC and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

Policy CC.COMP.22, Policy Management, details ATC's approach to the development and approval of policies and procedures by focusing on core business processes related to, among other things, compliance with laws and regulations, accreditation standards

and/or contractual requirements. Policies are reviewed annually at a minimum. Employees can access policies on the RSA Archer platform.

The 2022 ATC Organizational Chart and supplemental department charts identify key positions required by the *SCDHHS Contract* and delineate departmental oversight to ensure that all health care products and services are provided to members. Onsight discussion provided clarity regarding positions filled from the time of the desk materials submission, along with name and position clarification.

The 2022 Compliance Plan Matrix and Attachments provide details about ATC's compliance program and applicable federal and state laws, regulations, accreditation standards, and contractual obligations. The Business Ethics and Code of Conduct describes ATC's expectations for conducting business in accordance with the standards and rules of ethical business conduct and applicable laws and regulations. Comprehensive compliance training and education is overseen by the Compliance Department as part of the new hire and annual training.

The Compliance Committee Charter outlines the initiatives aimed at preventing, detecting, and correcting non-compliance with federal and state requirements, as well as measures that prevent, detect, correct, and deter fraud, waste, and abuse. Employees and management are encouraged to report any problems or concerns to their supervisor, manager, the Compliance Department, any member of ATC's Senior Leadership team, or the Corporate Compliance officer.

Excessive use of the pharmacy benefit is monitored by ATC following the process outlined in Policy SC.PHAR.06 Pharmacy Lock-in Program. Members identified and confirmed through analysis and review by the Pharmacy Department are restricted one specific pharmacy for two years.

Confidentiality and Health Insurance Portability and Accountability Act (HIPAA) requirements are addressed in Policy CC. COMP.PRVC.01, Privacy Program Description, the Employee Handbook, and in the Compliance Plan Matrix.These documents describe ATC's policies and responsibilities to protect the confidentiality of, and to guard against unauthorized access to or disclosure of, Protected Health Information.

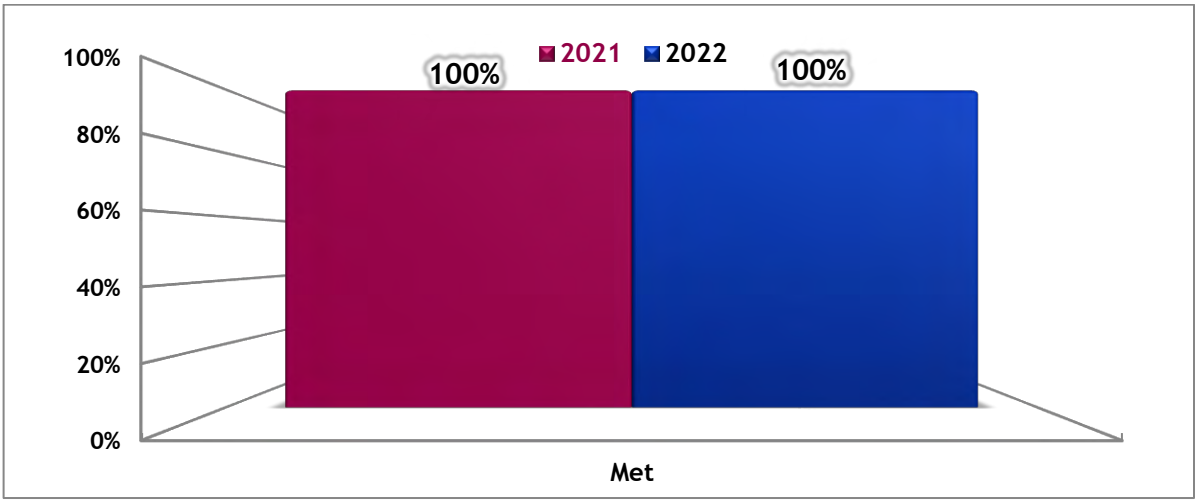
Information Management Systems Assessment

ATC's Information Systems Capabilities Assessment (ISCA) document indicates ATC is capable of meeting SCDHHS' contract requirements. The organization regularly reviews and updates the policies it uses to maintain data and system security. ATC conducts internal audits to ensure requirements are being met, and regularly contracts with auditors to verify its system controls. ATC's disaster recovery plan adheres to and

surpasses industry best practices. This was confirmed by the organization's Disaster Recovery test results.

In the Administration section of the review, ATC received "Met" scores for 100% of the standards, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings



Strengths

- ATC conducts regular independent audits of system security controls.
- Confidentiality is clearly and consistently addressed in Policy CC. COMP.PRVC.01, Privacy Program Description, the Employee Handbook, and in the Compliance Plan Matrix.
- Policy CC.COMP.16 Fraud, Waste, and Abuse Plan, provides detailed processes for ATC's data review, auding, and monitoring procedures.

B. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

The review of Provider Services encompasses processes for credentialing and recredentialing, ensuring network adequacy, initial and ongoing provider education, adopting and disseminating preventive health and clinical practice guidelines, ensuring continuity of care, and assessing practitioner compliance with medical record documentation standards.

Provider Credentialing and Selection

42 CFR § 438.214, 42 CFR § 457.1233(a)

The Centene Corporation Credentialing Program Description provides a brief overview of the Credentialing Program. Detailed information about credentialing processes and requirements is found in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. Although Policy CC.CRED.01 defines the timeframe within which ATC processes practitioner credentialing applications, corresponding information is not found in Policy CC.CRED.09 for organizational providers. Also, Policy CC.CRED.01 defines circumstances under which a practitioner may appeal the denial of a credentialing application, but corresponding information was not noted in Policy CC.CRED.09.

The Credentialing Committee meets monthly and is a subcommittee of the health plan's QIC, which has authority over the Credentialing Program. The QIC delegates oversight of credentialing functions to ATC's Medical Director, who serves as Chair of the Credentialing Committee. The Credentialing Committee Policy (CC.CRED.03) describes the structure and processes used to make recommendations regarding credentialing. The Credentialing Committee Charter found on page 13 of the 2022 Quality Program Description states the committee composition includes network practitioners. However, the 2022 committee roster indicates one external practitioner member of the committee, who is not an employee of ATC or Centene, is not a network provider. During onsite discussion of this finding, ATC staff reported that non-participating providers may serve as Credentialing Committee members. This is not compliant with footnote number five on page three of Policy CC.CRED.03, Credentialing Committee, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers."

Documentation of member attendance was unclear in the Credentialing Committee minutes due to a lack of a key defining the indicators used to document attendance. Examples include:

- For the November 8, 2022, Credentialing Committee meeting, one practitioner's attendance was designated with the letter "E." There was no key to denote the meaning of this symbol. This was discussed with health plan staff who first reported that the "E" signified an excused absence; however, staff later reported the "E" signified that attendance/voting for the practitioner was through email.
- On all committee minutes, member attendance was documented with an "X" or a dash ("-"). There was no key to denote the meaning of these symbols. Onsite discussion revealed that an "X" indicates the member was present and a dash indicates the member was absent.

- One practitioner was designated as absent from the committee meetings (by using a dash) from February 2022 through November 2022. Onsite discussion revealed the practitioner was not a member of the committee after January 2022.

Review of initial credentialing and recredentialing files for practitioners revealed the files were fully compliant with all requirements. For the organizational provider credentialing and recredentialing files, one file for a rural health clinic (RHC) did not include a South Carolina Department of Health and Environmental Control (DHEC) license. A copy of the license was requested, and ATC responded after the onsite that the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7,* had been revised to remove the requirement for RHCs to be surveyed and licensed by DHEC. However, the requirement for DHEC licensure had not been removed from Policy CC.CRED.09, Attachment M, item 10, which stated, "Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS."

Credentialing staff conduct ongoing monitoring of network providers for sanctions and exclusions, to ensure that no payments are made to individual providers or entities who are excluded from participation in any Federal health care program. The Quality Improvement and Credentialing Programs monitor the quality and safety of practitioner services, and the Credentialing Committee makes decisions about provider suspensions, restrictions, or terminations after investigations are conducted.

Availability of Services

ATC evaluates access to PCPs, specialists, and ancillary providers by conducting monthly Geo Access mapping to determine the number and geographic distribution of providers using standards defined by SCDHHS. When evaluating network adequacy, ATC also monitors member grievances related to practitioner access. The network evaluation includes analyzing the causes of any identified deficiencies, identifying barriers and opportunities for improvement, and prioritizing actions to address any identified network gaps. The Absolute Total Care (ATC) Network Strategy Overview January 2023 document indicates ATC expanded its network beginning in 2022 and continues to add providers. For the Medicaid network, ATC has been focusing on pediatrics and obstetrics/gynecology, and is working to contract with independent, free standing ambulatory surgery centers. In addition to geographic adequacy, ATC evaluates primary care, behavioral health, and specialty provider compliance with appointment access standards annually. ATC analyzes the results and makes recommendations to address any identified issues.

Table 9: Previous Adequacy of the Provider Network QIP Items lists a repeat issue identified during the previous EQR related to omission of a SCDHHS required Status 1 provider type from the Geo Access mapping conducted to assess network adequacy. The

findings of the current EQR reflect ATC addressed this deficiency and all required Status 1 provider types are included in Geo Access mapping.

Table 9: Previous Adequacy of the Provider Network QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	As stated in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC measures practitioner type and availability annually. Also included in the assessment of the network are survey results and grievance data regarding satisfaction with practitioner availability. Results are reported and reviewed by the Quality Committee which makes recommendations to address any identified deficiencies. The Geo Access mapping dated November 10, 2021, did not include results for all SCDHHS-designated Status 1 provider types as it did not include Pediatrics practitioners. This is a repeat finding from the previous EQR. This finding was discussed with ATC staff during the onsite, and additional information was provided that "when GEO Access Reports were generated, Pediatrics was inadvertently omitted from the report." *Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all SCDHHS-designated Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
ATC Response: A checklist of all status 1 providers has been developed to ensure when reviewing the reports, we capture all providers as required by SCDHHS.	

To ensure the network can meet members' needs, ATC assesses the membership's cultural, ethnic, racial, and linguistic needs annually. ATC collects corresponding information for practitioners on a voluntary basis through credentialing processes. In addition, data from member satisfaction surveys and grievances are monitored to identify areas for possible improvement. ATC uses the results of these activities to make network adjustments as needed.

Policy CC.PRVR.19, Provider Directory – Portico, states ATC maintains a searchable, printable, web-based Provider Directory that includes all network providers. The policy lists elements that must be included in the Provider Directory and details processes for maintaining provider information for inclusion in the directory. Review of the web-based Provider Directory confirmed all required elements are included.

Provider Access and Availability Study

42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

As part of the annual EQR process for ATC, CCME conducted a provider access study to evaluate the accuracy of provider contact information. This study focuses on primary care providers in ATC's network. A list of current providers was given to CCME by ATC, from which a population of 2,291 unique PCPs was identified. A sample of 190 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

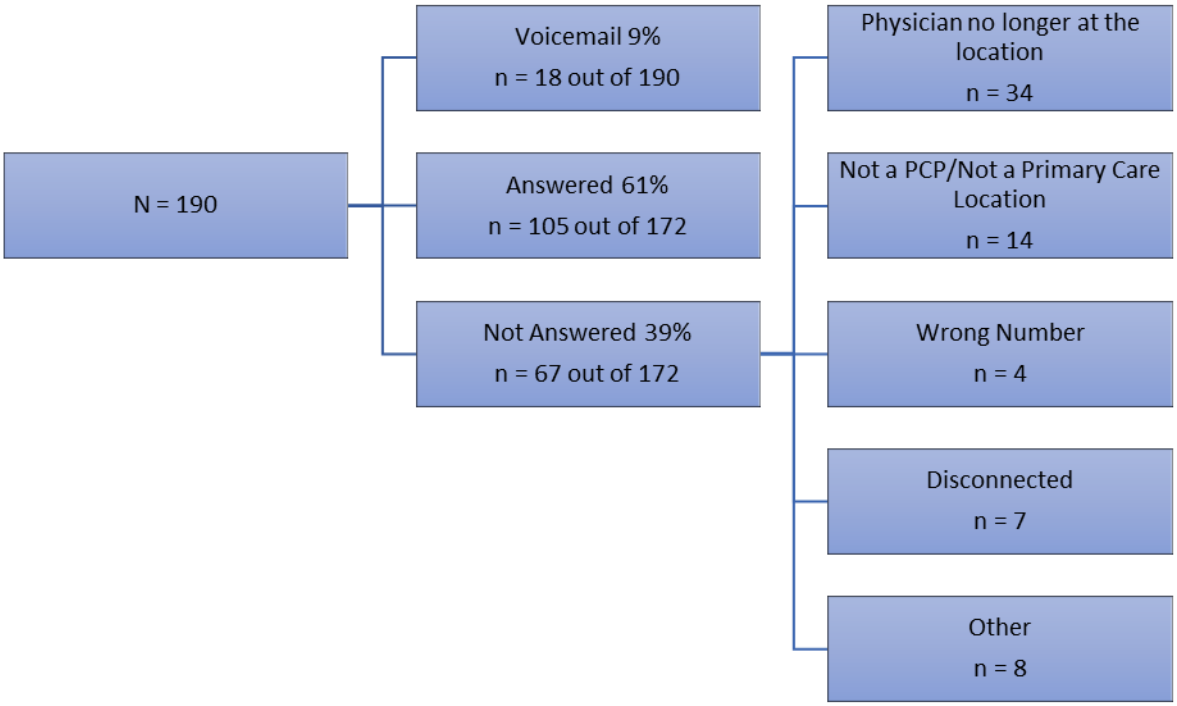
Calls were successfully answered 61% of the time (105 out of 190) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 61%, this year's study had no change in successful calls at 61% (p=.977), as shown in *Table 10: Telephonic Access Study Answer Rate Comparison*.

Table 10: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2021 Review	178	61%	.977
2022 Review	190	61%	

Figure 3: Telephonic Provider Access Study Results provides an overview of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



For the 67 calls not answered successfully, 34 (51%) were because the provider was no longer an active PCP at the location. For the question "Do you accept Absolute Total Care?" 95 out of 105 (90%) confirmed that they accept ATC. Of those 95 providers, 59 (62%) indicated they were accepting new Medicaid patients, and 27 of those 59 (46%) stated they have prescreening requirements. Of those 27 providers with prescreen requirements, eight (30%) required an application, 15 (56%) required a medical record review, three (11%) required both, and one (4%) required both as well as vaccine records.

Table 11: Previous Adequacy of the Provider Network QIP Items displays the 2021 EQR finding that, for the provider access study conducted by CCME, there was a decrease in successful calls compared to the 2020 results. ATC's response to the finding from 2021 is also noted in the table.

Table 11: Previous Adequacy of the Provider Network QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	

Standard	EQR Comments
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	As part of the annual EQR process for ATC, a provider access study was conducted focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,268 unique PCPs was found. A sample of 178 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time (96 out of 157) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's result of 73%, this year's study had a decrease in successful calls at 61% (p=.0257), representing a statistically significant decrease of 12%. *Quality Improvement Plan: Determine additional methods to maintain updated information, such as current provider practice locations, in provider files. Increase E-Verify usage to more than four times per year to increase accuracy of provider files.*
ATC Response: The LexisNexis (vendor) E-Verify campaigns currently run on a three-month cycle with reminders sent via USPS and email. Absolute Total Care will access LexisNexis capabilities and the appropriateness of increasing E-Verify usage to more than four times per year to increase accuracy of provider files. In addition, Absolute Total Care will be working with LexisNexis to evaluate targeted providers and data feeds to support current campaign schedule. Provider Relations will continue to educate practitioners on the process to submit changes timely to health plan to improve the accuracy of the information to ensure Physician Directory database is current. Onsite and/or virtual educational activities will occur during New Provider Orientations, monthly/quarterly provider joint operating committee meetings, quarterly town hall sessions, etc. Additional reminders will be deployed in the quarterly provider newsletter in the *"Updating Provider Directory Information"* section starting in 2022. Provider Relations and Provider Data Management will provide practitioner load reports to provider groups/physician offices to review for accuracy of data provided. Corrections identified by provider groups/physician offices will be updated in the Physician Directory database. Process was implemented in Q4 2021 and is on-going. Provider Relations staff to be trained/re-trained on completing real-time demographic updates in the Provider Data Update (PDU) tool. Staff will complete the updates upon notification of phone number changes and other updates permitted via PDU tool. Plan is exploring the opportunity to have Provider Relations conduct random call audits monthly to providers by assignment to confirm accuracy of phone numbers.	

Although there was no decrease in the percentage of successfully answered calls for the provider access call study conducted by CCME for the current review, there was also no

improvement. CCME encourages ATC to continue the interventions noted above and to seek additional ways to improve successful contact rates for future provider access call studies.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Initial provider orientation and education is conducted within 30 business days of the contract effective date for newly contracted providers who are not part of an established network group or facility. These education sessions are coordinated by Provider/Network Relations staff and include a variety of topics, including but not limited to overview of Centene, the role of Provider Network Specialists, provider responsibilities, utilization management processes, claims, fraud, waste, and abuse. The Provider Manual is a thorough resource that includes detailed information for providers to understand health plan operations and requirements. Ongoing provider education is accomplished through regularly scheduled meetings, quarterly regional provider training sessions, Provider Manual Updates, newsletters, ATC's website, etc.

ATC has established processes for reviewing and adopting preventive health and clinical practice guidelines and disseminating the guidelines to providers based on specialty and upon member and other provider request. New and revised guidelines are posted to ATC's website and may also be disseminated via provider orientation materials, newsletters, faxes, and special mailings.

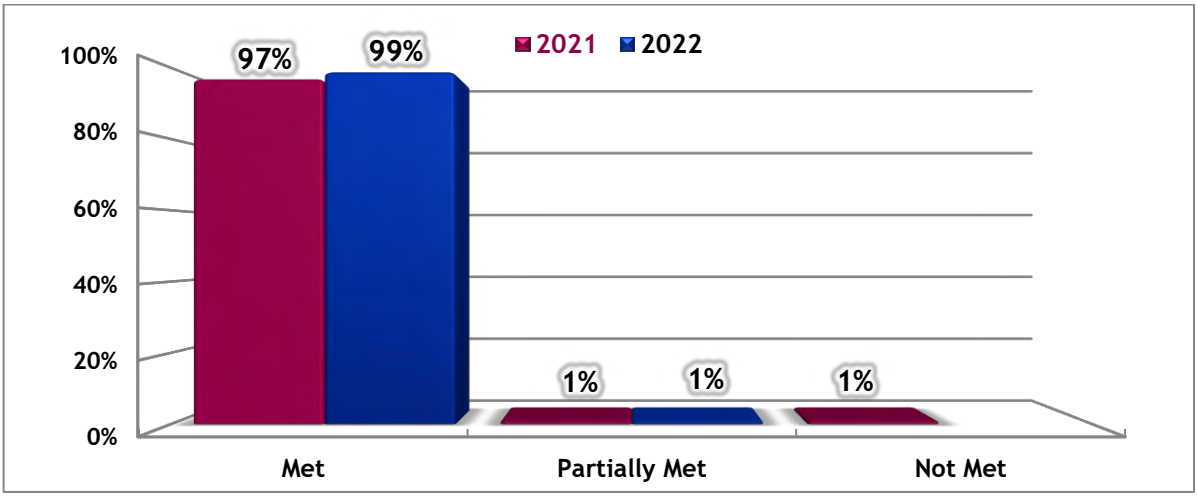
Providers are educated about medical documentation and maintenance requirements. Provider compliance with standards is assessed through annual medical record audits for PCPs, although providers may be included in the medical record audits as needed. Providers with scores below the 80% threshold are notified of deficiencies and actions required to address the deficiencies, and a follow-up audit is conducted within six months. Providers who continue to fall below the established scoring requirement are discussed with the Medical Director. Additional action may be taken, including additional medical record review by the Medical Director, referral to the QIC and/or Peer Review Committee, or termination of network participation. Audit results are presented annually to the QIC and used to identify opportunities for improvement. For the 2021 audit reported to the QIC in May 2022, the overall score was 96.4% and no practitioners scored below the required minimum score of 80%.

Providers are educated about Cultural Competency through the Provider Manual and ATC's website. The website allows providers to download the Cultural Competency and Linguistically Appropriate Services (CCLAS) Program Description, the Americans with Disabilities Act (ADA) – Disability Awareness Quick Reference Guide, and a Cultural Competency Quick Reference Guide. The website also links providers to "A Physician's

Practical Guide to Culturally Competent Care," an online, accredited program that provides continuing education credits for physicians and other clinicians.

As noted in *Figure 4: Provider Services Findings*, 99% of the standards in the Provider Services section of the EQR were scored as "Met." One standard related to the Credentialing Committee was scored as "Partially Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 12: Provider Services Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Credentialing and Recredentialing	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Partially Met
Adequacy of the Provider Network	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Credentialing and recredentialing files for individual practitioners were fully compliant with all requirements.
- ATC conducts routine monitoring of network adequacy, including monthly monitoring of geographic access to providers and annual evaluation of appointment accessibility. In considering adequacy of the network, ATC monitors member grievances about access to providers.
- The Network Strategy Overview document shows ATC is conducting various ongoing initiatives to expand and improve its network.
- ATC's Cultural Competency and Linguistically Appropriate Services (CCLAS) Program includes assessing the membership's cultural, ethnic, racial, and linguistic needs annually, collecting related practitioner cultural, ethnic, racial, and linguistic data through credentialing processes, and using results to make network adjustments as needed to ensure the needs of the membership are met.
- ATC's website provides cultural competency information, including the 2022 CCLAS Program Description, an Americans with Disabilities Act (ADA) – Disability Awareness Quick Reference Guide, a Cultural Competency Quick Reference Guide, and "A Physician's Practical Guide to Culturally Competent Care."
- The web-based Provider Directory includes all required elements.
- New provider education is conducted within 30 business days of the provider's contract effective date. Ongoing education is accomplished through regularly scheduled meetings for practitioners and quarterly Joint Operations Committee meetings for facilities. In addition, updates are provided through quarterly regional provider training sessions, Provider Manual Updates, newsletters, the website, etc.
- Appropriate processes are in place for review, adoption, and ongoing updates for Preventive Health and Clinical Practice Guidelines. The guidelines are disseminated to providers and others through various forums.
- Provider compliance with medical record documentation standards is assessed through annual medical record audits. Results are used to identify opportunities for improvement.

Weaknesses

- Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational providers. Also, this policy does not address circumstances under which an organizational provider may request reconsideration of a denial of credentialing into the network.

- The Credentialing Committee charter found on page 13 of the 2022 Quality Program Description states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider. This is not compliant with Policy CC.CRED.03, Credentialing Committee, page three, footnote number five, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers."
- Documentation of attendance of Credentialing Committee members at committee meetings was unclear. For example:
  - For the November 8, 2022, Credentialing Committee meeting, one practitioner with designated with the letter "E." When questioning health plan staff about the meaning of this designation, it was first reported that it signified an excused absence; however, staff then reported it signified attendance/voting for the practitioner was done by email.
  - CCME confirmed that an "X" indicates the committee member was present for the meeting, and a dash ("-") indicates the committee member was absent. However, one practitioner was designated as absent from February 2022 through November 2022. Onsite discussion revealed the practitioner was not a member of the committee after January 2022.
- One file for a Rural Health Clinic (RHC) did not include a DHEC license. A copy of this RHC's DHEC license was requested, and after the onsite, ATC responded that the Policy and Procedure Guide for Managed Care Organizations, Section 2.7, has been revised to remove the requirement for Rural Health Clinics to be surveyed and licensed by DHEC. This requirement, however, is still noted in ATC's Policy CC.CRED.09, Attachment M, item 10, which states, "Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS."
- For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time. When compared to last year's results of 61%, this year's study had no change in successful calls at 61%.

Quality Improvement Plan

- To comply with requirements of Policy CC.CRED.03, Credentialing Committee, replace the non-participating practitioner member of the Credentialing Committee with a participating network practitioner.

Recommendations

- Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers, and to include information about the availability for reconsideration of a denial of a credentialing application.

- Add a key to the Credentialing Committee Minutes to define the indicators used to indicate attendance. Ensure former committee members are designated as such on the Credentialing Committee minutes.
- Revise Policy CC.CRED.09, Attachment M, to remove the requirement that RHCs must be surveyed and licensed by DHEC if the plan is not operating under this requirement.
- Continue current interventions and seek additional interventions to improve successful contact rates for Provider Access Call Studies.

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Member Rights and Responsibilities are clearly and consistently outlined in the Member Welcome Packet, the Member Handbook, on ATC's website, and in Policy SC.MBRS.25, Member Rights and Responsibilities.

The New Member Welcome Letters are mailed within three days of receipt of the member listing. The benefits grid located in the Member Handbook, Provider Manual, and on ATC's website outlines services that require prior authorization, required co-payments, and any coverage limitations. Information on obtaining medications and medical equipment is clear. The steps for requesting assistance with interpretation services or materials in languages other than English are clearly outlined in ATC's printed materials and manuals.

Members have access to the nurse advice line 24-hours a day, seven days a week. Medical advice for children and adults, health information, assistance in determining where to go for care, answers to personal health questions, and information about pregnancy are all topics available by calling the nurse advice line. Information and instructions regarding family planning, women's services, and EPSDT services are available, along with specific resources.

Policy SC.ELIG.17, Enrollment, explains that the member enrollment process begins by selecting a Primary Care Provider. If the member does not select a provider, one will be auto assigned based on the member's zip code. Information on member disenrollment is provided in Policy SC.ELIG.10, Member Disenrollment. This policy indicates that all member requests for disenrollment are referred to SCDHHS or its designee. The effective date of an approved disenrollment request is noted as no later than the first day of the second month following the month in which the Medicaid Member filed the request.

Member Satisfaction Survey

ATC contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct both the child and adult member satisfaction surveys. CCME validated ATC's CAHPS survey and found ATC met all of the validation requirements for the surveys. Results of the CAHPS surveys were reported and discussed during the August 2022 QIC meeting.

The results of the Child with Chronic Conditions (CCC) survey found ATC showed improvements in the Getting Needed Care, Getting Care Quickly, and the Rating of Health Care measures. For the Adult CAHPS, Personal Doctor Spent Enough Time with the Patient improved significantly. The Child CAHPS results found improvements in the Getting Need Care, Getting Care Quickly, and the Rating of the Health Plan were all above the benchmark. The child survey response rate was 7.8% (198 out of 2558), which is a decline from last year's rate of 9.4%. The adult response rate was 10.3% (228 out of 2228) which is a decline from last year's rate of 12.1%. The CCC response rate was 7.2% (118 out of 1650) which is a decline from last year's rate of 9.6%. The minimum number of completed surveys is less than the NCQA target of 411 surveys for all three populations: Adult, Child, and CCC. The response rates are also below the NCQA target rate of 40%.

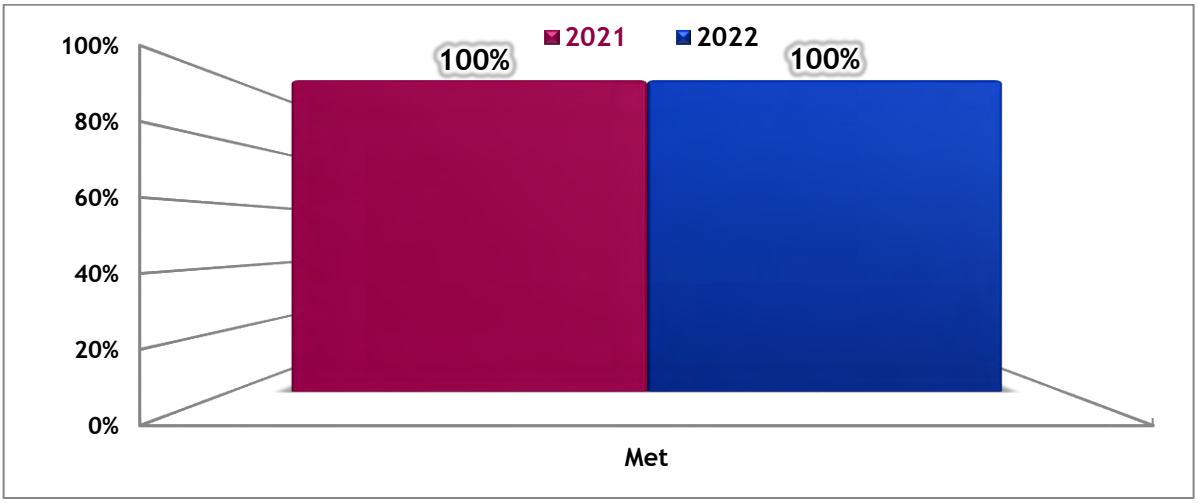
Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Policy SC.MM.11, Member Grievances, the Member Handbook, and ATC's website define grievance terminology, describe who can file a grievance, and provide instructions for filing a grievance and obtaining an authorized representative. Appropriate timeframes were outlined in the policy for grievance acknowledgement, extensions if needed, and resolution. Member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes. The grievance file review found that all grievances met timeliness standards.

ATC continues to meet all the requirements in the Member Services section as shown in *Figure 5 Member Services Findings*.

Figure 5: Member Services Findings



Strengths

- Fraud and abuse are defined in the Member Handbook and on the website. Examples and instructions are provided for members to anonymously report fraud and abuse to ATC and to SCDHHS' Division of Program Integrity.
- The grievance files reviewed for this EQR met timeliness standards for acknowledgment and resolution.
- Information for the process to obtain a Care Manager is provided in the Member Handbook. Referrals may be made by contacting the Member Services Call Center.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

ATC provided the 2022 Quality Improvement Program Description for this EQR. This program description provides an overview of the QI Program that ATC has established to improve the quality of care delivered to their members. The QI Program Description included the program's structure, goals, scope, and methodology.

Members and providers are provided information regarding the QI Program on ATC's website, in the Member Handbook and in the Provider Manual.

Annually, ATC develops a work plan to help manage workflow, assign tasks, and track various components of the QI Program. The 2021 and 2022 work plans included the scope, activity description and objectives, responsible party, timeline, and the status for each activity. During the previous EQR, CCME recommended that ATC include the oversight monitoring of all functions performed by a delegated entity in the QI work plan. ATC

included this recommendation in the QI work plan and added the oversight monitoring of the delegated entities.

ATC's Board of Directors delegates the operating authority of the QI Program to the QIC. The QIC is the senior management lead committee responsible for reporting the program's activities, findings, recommendations, actions, and results to the Board at least annually. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved.

ATC's Chief Medical Director chairs the QIC. Voting members for this committee include ATC's senior leaders and network practitioners specializing in Family Medicine, OB/GYN, Pediatrics, and Psychiatry. A quorum is defined as a minimum of three committee members including the committee chair, one health plan staff, and one external practitioner. The minutes submitted for this EQR demonstrated the presence of a quorum for each meeting.

The QIC Charter indicates meeting minutes will reflect the committee's decisions, actions, follow-up or next steps, and subcommittee reports. Per the charter, the minutes are completed no later than 30 days after the meeting. The minutes are reviewed and approved at the next regularly scheduled meeting. For this EQR, minutes were provided for meetings held from December 2021 through December 2022.

ATC requires all network providers to comply with the requirements outlined in the provider agreement, including participation with quality assessment and improvement activities. A sample provider agreement was provided that outlined these requirements. Network providers are also encouraged to participate through committees that play an active role in the directions and specific initiatives. ATC's website provides a summary of the QI Program with some HEDIS and CAHPS comparative results.

ATC's network providers receive feedback regarding their performance data through Provider Analytics, Interpreta, and a Physician Report Card. Provider Analytics is a quality, cost, and utilization tool designed to support providers who participate in a value-based program. This tool helps providers identify where to focus clinical efforts. Interpreta is an analytic tool available to providers for generating member care gap reports. ATC also generates a Physician Report Card annually and shares the results with high-volume pediatricians. The report card is based on specific HEDIS measures and compares their rates with ATC's overall health plan rates. The current provider performance metrics are Well-Child visits in the first 15 months of life, Well-Child visits for ages 15 to 30 months, and Child and Adolescent Well-Care visits.

Annually, ATC assesses the effectiveness of the QI Program and documents the assessment in the QI Program Evaluation. The 2021 Quality Improvement Program Evaluation was reviewed for this EQR, and included the results of activities and studies

underway or completed in 2021. A barrier analysis and any recommendations for 2022 to overcome those barriers were also included. The evaluation was submitted to the QIC in May 2022 and approved with no further recommendations.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures for the current measure year (2021), as well as the previous measure year (2020) and the change from 2020 to 2021 are reported in *Table 13: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 13: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	MEASURE YEAR 2020	MEASURE YEAR 2021	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	73.48%	65.94%	-7.54%
Counseling for Nutrition	61.07%	59.12%	-1.95%
Counseling for Physical Activity	57.18%	53.77%	-3.41%
Childhood Immunization Status (cis)			
DTaP	69.59%	64.23%	-5.36%
IPV	85.4%	79.56%	-5.84%
MMR	86.13%	81.51%	-4.62%
HiB	79.56%	73.97%	-5.59%
Hepatitis B	83.7%	77.13%	-6.57%
VZV	85.89%	81.02%	-4.87%
Pneumococcal Conjugate	72.75%	66.91%	-5.84%
Hepatitis A	83.94%	78.35%	-5.59%
Rotavirus	70.07%	64.48%	-5.59%
Influenza	41.36%	37.71%	-3.65%
Combination #3	63.26%	57.18%	-6.08%
Combination #7	55.23%	50.12%	-5.11%

MEASURE/DATA ELEMENT	MEASURE YEAR 2020	MEASURE YEAR 2021	PERCENTAGE POINT DIFFERENCE
Combination #10	31.14%	27.01%	-4.13%
Immunizations for Adolescents (ima)			
Meningococcal	70.56%	72.26%	1.70%
Tdap/Td	82.24%	81.75%	-0.49%
Combination #1	69.83%	72.02%	2.19%
Combination #2	29.93%	33.82%	3.89%
Human Papillomavirus Vaccine for Female Adolescents	31.63%	34.79%	3.16%
Lead Screening in Children (lsc)	67.85%	63.79%	-4.06%
Breast Cancer Screening (bcs)	57.55%	54.62%	-2.93%
Cervical Cancer Screening (ccs)	59.61%	61.8%	2.19%
Chlamydia Screening in Women (chl)			
Total	61.34%	61.77%	0.43%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	81.69%	74.17%	-7.52%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.44%	22.49%	-4.95%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	69.26%	68.83%	-0.43%
Bronchodilator	80.42%	80.97%	0.55%
Asthma Medication Ratio (amr)			
Total	70.89%	68.39%	-2.50%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	51.34%	42.82%	-8.52%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	79.07%	10.18%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	80.73%	79.5%	-1.23%
Statin Adherence 80% - Total	62.63%	59.11%	-3.52%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	5.06%	2.05%	-3.01%
Cardiac Rehabilitation - Engagement1 (Total)	4.64%	2.46%	-2.18%
Cardiac Rehabilitation - Engagement2 (Total)	4.64%	0.82%	-3.82%
Cardiac Rehabilitation - Achievement (Total)	2.53%	0.00%	-2.53%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.08%	84.91%	-3.17%
HbA1c Poor Control (>9.0%)	44.04%	37.23%	-6.81%

MEASURE/DATA ELEMENT	MEASURE YEAR 2020	MEASURE YEAR 2021	PERCENTAGE POINT DIFFERENCE
HbA1c Control (<8.0%)	47.69%	52.8%	5.11%
Eye Exam (Retinal) Performed	47.2%	48.42%	1.22%
Blood Pressure Control (<140/90 mm Hg)	52.55%	50.36%	-2.19%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	23.31%	23.56%	0.25%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	66.85%	65.82%	-1.03%
Statin Adherence 80%	59.59%	59.5%	-0.09%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	48.3%	51.59%	3.29%
Effective Continuation Phase Treatment	32.07%	35.89%	3.82%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	44.63%	37.55%	-7.08%
Continuation and Maintenance (C&M) Phase	63.28%	53.78%	-9.50%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	60.69%	59.23%	-1.46%
Total - 7-Day Follow-Up	38.5%	37.59%	-0.91%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	51.93%	51.2%	-0.73%
Total - 7-Day Follow-Up	37.06%	39.45%	2.39%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	40%	31.23%	-8.77%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	22.67%	17.03%	-5.64%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	12.29%	12.33%	0.04%
Total - 7-Day Follow-Up	8.98%	8.17%	-0.81%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.13%	76.8%	1.67%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	66.29%	68.39%	2.10%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA*	NA*	NR*
Pharmacotherapy for Opioid Use Disorder (pod)			
Total	40.31%	41.03%	0.72%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	63.81%	60.64%	-3.17%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			

MEASURE/DATA ELEMENT	MEASURE YEAR 2020	MEASURE YEAR 2021	PERCENTAGE POINT DIFFERENCE
Blood glucose testing - Total	46.39%	49.36%	2.97%
Cholesterol Testing - Total	27.11%	33.01%	5.90%
Blood glucose and Cholesterol Testing - Total	26.2%	31.09%	4.89%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.46%	1.34%	-0.12%
Appropriate Treatment for Children With URI (uri)			
Total	86.78%	87.8%	1.02%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	52.92%	54.37%	1.45%
Use of Imaging Studies for Low Back Pain (lbp)	69.25%	69.95%	0.70%
Use of Opioids at High Dosage (hdo)	2.49%	2.18%	-0.31%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	15.4%	15.8%	0.40%
Multiple Pharmacies	3.33%	1.08%	-2.25%
Multiple Prescribers and Multiple Pharmacies	1.35%	0.62%	-0.73%
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	5.38%	3.72%	-1.66%
Total - >=31 Days covered	2.66%	2.42%	-0.24%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	79.56%	78.18%	-1.38%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.32%	41.84%	-3.48%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.00%	6.09%	-0.91%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	59.46%	58.62%	-0.84%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	31.45%	33.52%	2.07%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	42.93%	40.57%	-2.36%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	9.37%	7.26%	-2.11%
Initiation of AOD Treatment: Total	45.08%	43.41%	-1.67%
Engagement of AOD Treatment: Total	11.97%	10.99%	-0.98%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	89.54%	85.64%	-3.90%
Postpartum Care	76.89%	69.83%	-7.06%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			

MEASURE/DATA ELEMENT	MEASURE YEAR 2020	MEASURE YEAR 2021	PERCENTAGE POINT DIFFERENCE
Total	53.62%	61.2%	7.58%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	50.75%	55.64%	4.89%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.74%	68.65%	-1.09%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	43.17%	45.12%	1.95%

Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator

As shown in the table that follows, the Persistence of Beta Blocker Treatment After a Heart Attack showed a 10.18% increase. There were no rates that showed a substantial decrease.

Table 14: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	79.07%	10.18%

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled *EQR Protocol 1: Validating Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

ATC submitted two PIPs for validation. Topics for the PIPs included Adult Access to Preventive Health Care and Hospital Readmissions. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions is included.

Table 15: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The baseline rate was CY2020 with a rate of 77.28%. The rate improved at remeasurement 1 (CY2021) to 78.18%. The goal is 81.97%.	
Previous Validation Score	**Current Validation Score**
Not submitted	80/80=100% High Confidence in Reported Results
Interventions	
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • ATC will utilize a vendor, Eliza, to supplement outreach by the Quality Department staff to assist with scheduling appointments. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. • Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.	

Table 16: Hospital Readmissions PIP

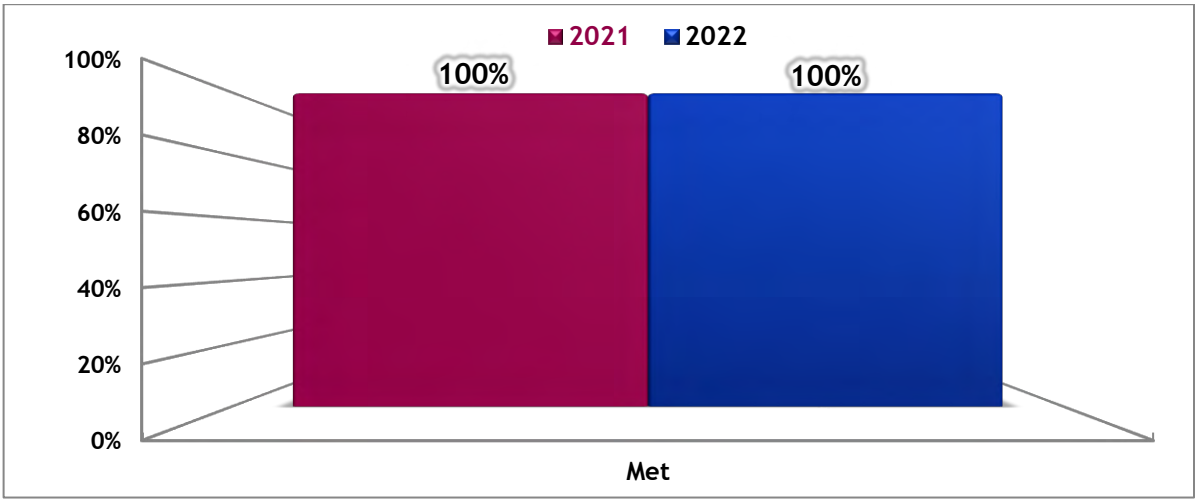
Hospital Readmissions	
The Readmissions PIP aims to reduce annual rate of readmissions within 30 days for 18–64-year old patients. The baseline rate was 18%, which was reduced to 16.2%, and further reduced to 15.5% for remeasurement 2 (ending June 2022). The goal was to reduce the rate to 15.5% and the goal was therefore met.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Hospital Readmissions
• Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists member with scheduling appointment within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. Quarterly meetings are held with managers and the TOC team to discuss the TOC process. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • Members at risk for readmission based on most frequently admitted diagnosis are referred to the Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management. • Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

ATC continues to meet all the requirements in the Quality Improvement section of the review as noted in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings



Strengths

- ATC's QI Program Description and Program Evaluation was detailed and included all required elements.

- The Persistence of Beta Blocker Treatment After a Heart Attack HEDIS rate showed a 10.18% increase.
- PIPs were based on analysis of comprehensive aspects of member needs and services, and rationale for each topic was documented.
- Both PIPs met the validation requirements and received validation scores within the High Confidence Range.
- The remeasurement rates for both PIPs showed an improvement in the adult preventative care rate and improvements in the hospital readmission rate.
- ATC's network providers receive feedback regarding their performance data through Provider Analytics, Interpreta, and a Physician Report Card.

E. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

ATC's Utilization Management Program Description outlines staff responsibilities, the program's scope, and program objectives for physical health and behavioral health services. ATC's pharmacy program is integrated in the UM program to ensure access and manage pharmacy authorizations.

ATC's UM Program Description, Centene Advanced Behavioral Health UM Program Description, and the Pharmacy Program Description provide a descriptive overview of the roles and responsibilities of the Medical Director, Behavioral Health Director, and Pharmacy Director. The Medical Director is a physician responsible for providing clinical oversight of all clinical activities. The Medical Director is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews. A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of ATC's UM program.

Coverage and Authorization of Services

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228

Initial clinical reviews are conducted by health care professionals who hold current licensure as a Registered Nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or other appropriately licensed health care professionals. Initial clinical review staff have access to licensed clinical medical directors if a Level II medical necessity review is needed. Review of approval and denial files reflect decisions are made by appropriate clinical staff.

Various evidenced based clinical criteria and other guidelines are used to render clinical determinations. These criteria/guidelines include InterQual, American Society of

Addiction Medicine (ASAM), etc. ATC's Pharmacy Benefit Program uses prior authorization criteria that is developed by the Clinical Pharmacy Advisory Committee (CPAC). The sample of approval files reviewed during this EQR reflected use of appropriate criteria when making clinical determinations. Additionally, the clinical determinations were completed within the required contractual guidelines for standard and expedited requests.

To ensure consistency in clinical criteria application, ATC conducts annual Inter-Rater Reliability (IRR) testing for physicians and non-physician UM reviewers. For the Medical IRR testing, the overall average score was 94%, and the overall Behavioral Health IRR score was 98%. These scores exceeded the goal of 90%.

Overall, UM denial files reflected requests for additional clinical information when needed prior to making an adverse benefit determination. However, for one file, the additional information was requested after completion of the review decision. Review of the denial decisions demonstrated prompt communication of the adverse benefit determination to the member. The reasons for denial decisions and the right to request a State Fair Hearing were also appropriately communicated. For two denial files, the adverse benefit determination notices incorrectly indicated that a written appeal is required within 14 days of an oral appeal request. However, this is no longer a contractual requirement. During the onsite discussion, ATC staff reported they had already identified this as a concern and that previously there were two different versions of the Adverse Benefit Determination notice in the system and staff were not consistent in utilizing the updated notice. ATC described actions taken to address the issue, including that it was corrected in the Spring of 2022 by removing the old letter template from the system.

As described in *Table 17 Previous Pharmacy Formulary Restrictions Deficiency and Quality Improvement Plan*, during the 2021 EQR, ATC received a deficiency regarding the negative Preferred Drug List (PDL) changes and how or when those changes are published on ATC's website as required by the SCDHHS contract. CCME found ATC implemented a new template that documents the posted date and the effective date for the changes made to the PDL.

Table 17: Previous Pharmacy Formulary Restrictions Deficiency and Quality Improvement Plan

Standard	EQR Comments
V B. Medical Necessity Determinations	

Standard	EQR Comments
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Policy CC.PHAR.10, Preferred Drug List, describes ATC's policy for maintaining the Preferred Drug List and identifying pharmaceutical management controls to ensure appropriate use of the health plan's pharmacy benefit. The Preferred Drug List provides formulary restrictions and indicates medications requiring prior authorization, limitations, or step therapy. Processes for members to obtain over-the-counter medications are described in the Member Handbook. Per Policy CC.PHAR.10, Preferred Drug List, negative PDL changes are communicated to affected members and their prescribing practitioners at least 30 days in advance via the health plan website. However, some of the issues identified with this notification included: •The Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020. •1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were PDL changes discussed during the meeting and not included on the website notice. •Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021, P&T meeting and posted on the website; however, the effective date was January 1, 2021, which was before the committee met. *Quality Improvement Plan: Address in a policy or desk procedure the process for ensuring negative PDL changes are published on the website at least 30 days prior to implementation as required by SCDHHS Contract, Section 4.2.21.2.3. Ensure members and their prescribing practitioners are notified at least 30 days in advance of negative PDL changes via the health plan website. Consider including the date the notices are published on the website.*
ATC Response: Pharmacy Department staff will be provided with a copy of the new desk procedure which will outline in detail the steps that need to be taken any time a negative change is made to the PDL. This workflow will reemphasize the minimum thirty-day advance notice to members and providers	

Standard	EQR Comments
required in the contract with the State, and also the minimum thirty day posting of the changes to the website of any negative changes to the PDL as required. A new template has been created to address the issue that only effective date was listed previously on the PDL change documents listed on the website. The new template will have both the posted date (or date the PDL change document was posted on the website) and the effective date (or the date that the changes will be effective). This new template will make it easy to determine if regulatory deadlines regarding posting were met when negative changes are made to the PDL.	

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

Policy SC.MM.13, Member Appeals, the UM Program Description, the Provider Manual, and the Member Handbook outline ATC's appeal process, appropriately define the terms "adverse benefit determination" and "appeal," and includes information that a member or a member's authorized representative, on behalf of the member, may file an appeal. Review of the appeal files reflected that the appeal guidelines and processes were followed according to contractual standards.

Quarterly, a summary of member appeals is reviewed by the Utilization Management Committee to identify trends and opportunities to improve the quality of care and services. The Utilization Management Committee minutes and appeals review summary were presented and approved by the Quality Improvement Committee.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

A descriptive overview and the approaches of ATC's Care Management Programs are included in Policy CC.CM.01, Care Management Program Description, Policy CC.CM.02, Care Coordination/Care Management Services, Policy SC.UM.41, Transition of Care, and the Population Health Management Strategy document.

ATC members are referred for Care Management services through various sources such as provider referrals, vendor referrals, self-referrals, department referrals, delegated entities, and many other referral sources. Additionally, it was indicated that direct referrals are considered high priority referrals for Care Management services. The Care Management Program Description and various policies provide an overview of the guidelines and care management activities provided for members receiving behavioral health services.

As described in Policy CC.CM.08 Care Management Member Satisfaction Survey, ATC conducts member satisfaction surveys monthly for members who have been enrolled in the Care Management Program for at least 30 days. The feedback allows for individual Care Management feedback and training. Additionally, a qualitative analysis is conducted to identify any trends and opportunities for improvement. Annually, ATC evaluates the effectiveness of the program by selecting various metrics for each program.

ATC's Care Management files indicated that Care Management activities are conducted as required.

As described in *Figure 7*, for the 2022 EQR, ATC achieved scores of "Met" for 100% of the standards in the UM Section.

Figure 7: Utilization Management Findings

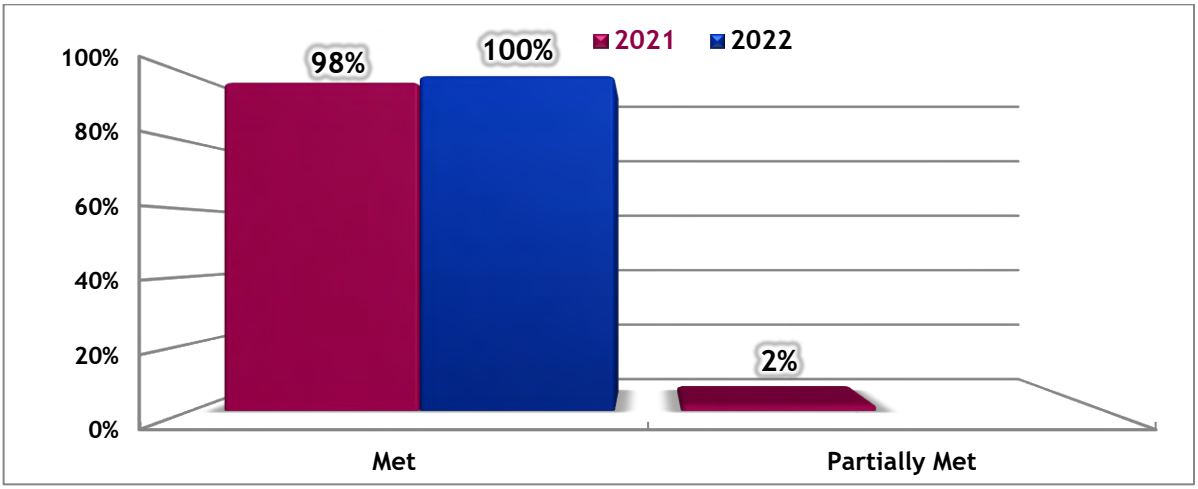


TABLE 18: Utilization Management Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Pharmacy Requirements	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- All approval and denial files were completed within contractual guidelines.
- The overall result of the Medical IRR testing domains generated an average score of 94%, and an average score of 98% for Behavioral Health. These scores exceeded the goal of 90%.

- Within the denial files, the Member Authorization Form and Member Appeal Form were attached to the adverse benefit determination notices for member convenience.

Weakness

- For two denial files, the adverse benefit determination notices incorrectly indicated that a written appeal is required within 14 days of an oral appeal request. This is no longer a contractual requirement.

Recommendation

- Re-educate staff regarding the new adverse benefit notifications.

F. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

CCME's review of delegation functions included ATC's delegate list, sample delegation contracts, delegation monitoring materials, and delegation oversight documentation.

ATC reported delegation agreements with 25 entities listed in *Table 19: Delegated Entities and Services*.

Table 19: Delegated Entities and Services

Delegated Entities	Delegated Services
• Envolve People Care - Behavioral Health	• Behavioral Health Service Authorizations and Denials, Member and Provider Denial Letters • Complaints - Provider Generated
• Envolve People Care – Nurse Advice Line	• Member Calls • Nurse Hotline • Triage • Provider Calls
• Envolve People Care - Disease Management	• Disease Management
• Centene Pharmacy Solutions	• UM Service Authorizations, Provider Denial Letters • Provider Generated Complaints • Claims Adjudication • Network Development & Maintenance
• CVS Caremark	• Pharmacy Claims
• Envolve Vision	• Claims Adjudication and Provider Claim Appeals • Credentialing and Recredentialing • Network Development and Maintenance

Delegated Entities	Delegated Services
• NIA	• UM Service Authorizations, Member and Provider Denial Letters • Credentialing and Recredentialing • Network Development and Maintenance
• Turning Point	• UM Service Authorizations
• New Century Health	• UM Service Authorizations
• CVS Health • Lexington • MUSC • RHP Spartanburg • Roper St. Frances Physicians Network • United Physicians • AnMed Health • AU Medical Center • Bon Secours • GHS Prisma Health • MNS • Palmetto Health USC • Self Regional Health Care • HNS • Preferred Care of Aiken • St. Francis Bon Secours	• Credentialing

Prior to executing a delegation agreement, ATC evaluates potential delegates to ensure they can conduct the activities in compliance with health plan standards and requirements of the *SCDHHS Contract*, NCQA, etc. A written delegation agreement is signed by both parties and defines the functions to be delegated, performance expectations, reporting requirements, and consequences for substandard performance. These processes are documented in Policy SC.UM.18, Oversight of Delegated Utilization Management, and Policy CC.CRED.12, Oversight of Delegated Credentialing.

The policies note that ATC retains accountability for delegated services and monitors delegate performance through routine delegate reporting and at least annual formal evaluations. CCME reviewed oversight documentation submitted by ATC and found that ATC did not submit annual oversight documentation for one delegate. This was discussed during the onsite visit; ATC staff reported that an annual evaluation was conducted in 2022 and that delegation to this entity would not continue in 2023. Although ATC reported they would provide evidence of the 2022 annual evaluation, no documentation was received. Documentation of annual oversight for the remaining delegates included

appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.

Policy CC.CRED.12, Oversight of Delegated Credentialing, states:

- Summaries of routine oversight meetings and evaluations of interim reporting are presented at the next regularly scheduled Credentialing and/or QIC for review and approval. Refer to section III (C) of the policy.
- A summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities and presented to the Credentialing and/or QIC for review and approval. Refer to Section IV (E).
- Reports about any ongoing corrective action plans will be presented to Plan Credentialing/QIC at least quarterly. Refer to Section V (E).

During onsite discussion, it was reported that results of the oversight activities for credentialing delegates are reported to the Credentialing Committee. However, the submitted Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight, including the items specified in Policy CC.CRED.12 above. Further, the 2021 QI Program Evaluation, page 117, indicates that for all Credentialing delegates, the Credentialing Committee reviewed the results of credentialing delegate audits during the February 8, 2022, meeting. There was no documentation in the Credentialing Committee minutes to support this.

Health plan staff confirmed that the Credentialing Committee minutes submitted for review were the final minutes. However, copies of Credentialing Committee minutes attached to QIC meeting binders reflected discrepancies for two sets of minutes when compared to the minutes submitted for review. After completion of the onsite review, a statement was received from ATC/Centene staff that the originally submitted minutes were not final.

As noted in *Figure 8: Delegation Findings*, 50% of the standards in the Delegation section of the review were scored as "Met."

Figure 8: Delegation Findings

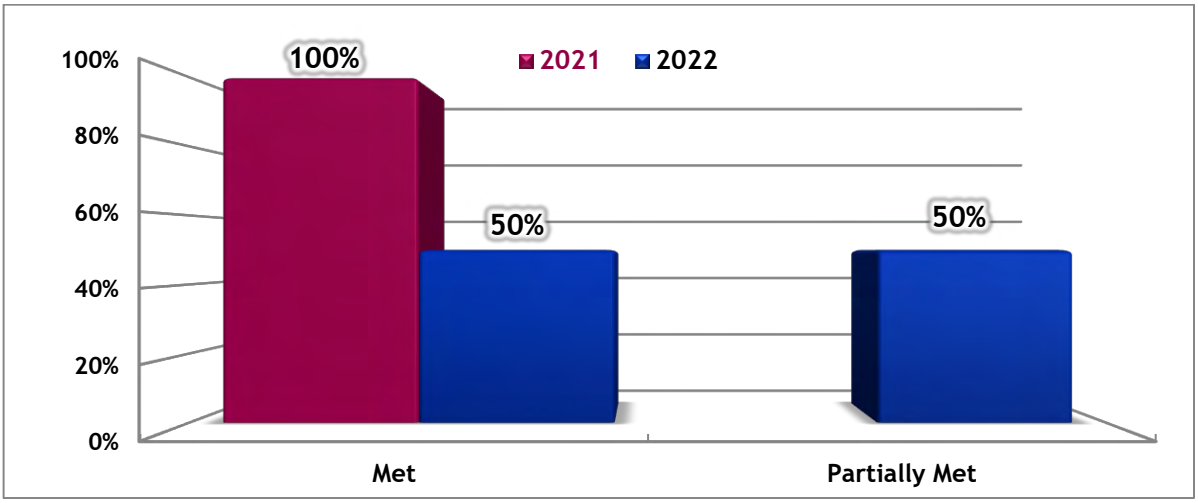


Table 20: Delegation Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Policies thoroughly document delegation processes and requirements.
- Annual oversight documentation included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.

Weaknesses

- No annual oversight documentation was submitted for one delegated entity. ATC staff reported that an annual evaluation was conducted in 2022 and that they would provide the documentation, but it was not received.
- Policy CC.CRED.12, Oversight of Delegated Credentialing, states information about credentialing delegation oversight is reported to the QIC and/or the Credentialing Committee. During the onsite, health plan staff clarified that this information is reported to the Credentialing Committee. However, the Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight.

Quality Improvement Plans

- Ensure annual evaluations are conducted for each delegated entity.
- To comply with requirements of Policy CC.CRED.12, Oversight of Delegated Credentialing, implement actions to ensure that either the QIC or Credentialing Committee receives and reviews summaries of routine oversight meetings, evaluations of interim reporting, a summary of the annual delegation review via the Report of Delegation Oversight Activities, and reports about any ongoing corrective action plans.

G. State Mandated Services

42 CFR Part 441, Subpart B

ATC provides all core benefits required by the *SCDHHS Contract*.

ATC assesses provider compliance with administration of recommended immunizations and the provision of required EPSDT services through annual medical record compliance audits and by monitoring HEDIS reporting measures. ATC routinely disseminates lists of noncompliant members and members with gaps in care to PCPs, and educates providers about EPSDT requirements and recommended immunizations in a variety of ways, including new provider orientation, the Provider Manual, the website, newsletters, etc.

Findings of the current EQR confirmed ATC corrected all issues identified during the previous EQR. *Table 20: Previous State Mandated Services QIP Items* displays the finding of the previous EQR related to uncorrected deficiencies and ATC's response to the finding.

Table 20: Previous State Mandated Services QIP Items

Standard	EQR Comments
State Mandated Services	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	During the previous EQR, Geo Access mapping reports did not include all required SCDHHS-designated Status 1 provider types. In the current EQR, it was again noted that the Geo Access mapping reports did not include all required Status 1 provider types. *Quality Improvement Plan: Ensure corrections for all deficiencies identified in the EQR are addressed and fully implemented.*
ATC Response: Compliance coordinates directly with all Business Owners to ensure that identified deficiencies are addressed. As an additional control for the GEO Access mapping report. Compliance has developed a checklist of Status 1 provider types and will review these reports to ensure all providers are addressed.	

As noted in *Figure 9: State Mandated Services*, all standards in the State Mandated Services section of the review are scored as "Met."

Figure 9: State Mandated Services

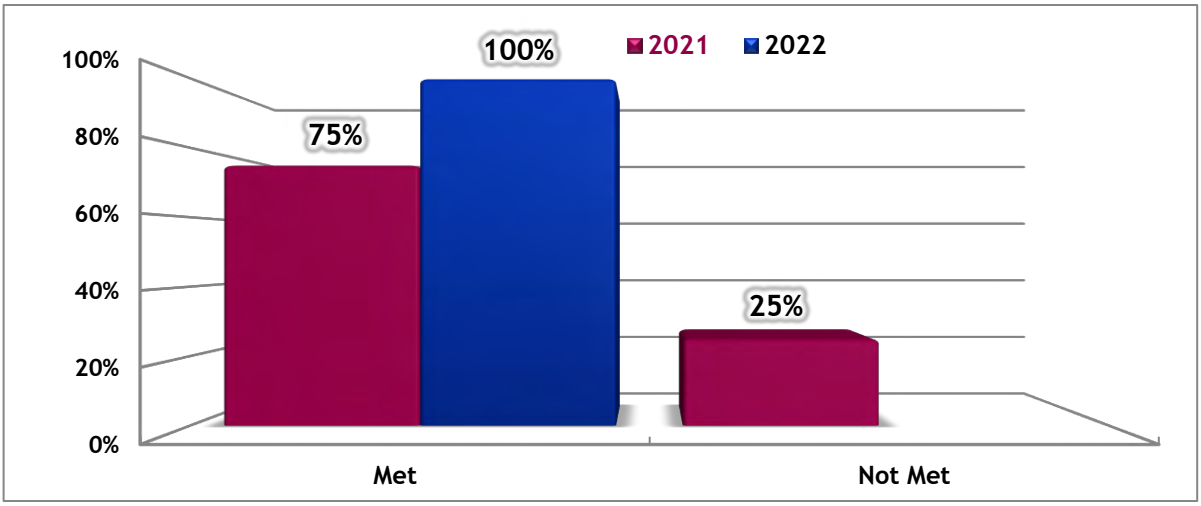


Table 20: State Mandated Services Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- All required core benefits are provided to members.
- ATC routinely evaluates provider compliance with recommended immunizations and required EPSDT services.
- ATC corrected all deficiencies identified during the previous EQR.

ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

November 7, 2022

Mr. John McClellan
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. McClellan:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2022 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The two day onsite will be conducted virtually on **February 1st and February 2nd.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 12, 2022.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2022/2023

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. Please provide a list of all current employees, the employees title, and credentials.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers **that serve as a PCP** for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2021 and 2022.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e., analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services. Please provide the over and underutilization summary report(s) and the quarterly or monthly monitoring reports.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from December 2021 through November 2022. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member (i.e., CAHPS and ECHO), a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of December 2021 through November 2022.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. Provide a listing of all delegates conducting delegated activities. Please include both local health plan delegates and corporate delegates that conduct activities for South Carolina using the following format:

Date of initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated, i.e., credentialing, behavioral health, utilization management, external review,

case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    - **a. final HEDIS audit report**
    - b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    - c. reporting frequency and format;
    - d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    - e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    - f. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    - g. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    - **h. calculated and reported rates.**
    - **i. Please include the point value, and index scores for the SCDHHS withhold measures.**

36. Electronic copies of the following files:
    - a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of December 2021 through November 2022. Include any medical information and physician review documentation used in making the denial determination.
    - d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of December 2021 through November 2022, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery

and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeal, Grievance, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. South Carolina specific attachment to Policy CC.PRVR.47, Evaluation of Practitioner Availability.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	Absolute Total Care
Name of PIP:	ADULT ACCESS TO PREVENTIVE HEALTH CARE (AAP)
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addressed enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was defined in report.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure focused on processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources were listed.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection used administrative data programming logic to pull information.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data were collected using QSI XL certified software.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis was listed as annually with monthly data collection.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel as provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were clearly presented.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement were documented in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data was included in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were directly related to barriers identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The baseline rate was CY2020 with a rate of 77.28%. The rate improved at remeasurement 1 (CY2021) to 78.18%. The goal is 81.97%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The improvement was related to the interventions although tracking will continue with a new goal rate of 15%.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis using chi square was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**80**
Project Possible Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	Absolute Total Care
Name of PIP:	HOSPITAL READMISSIONS - CLINICAL
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addressed enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was defined in report.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure focused on processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources were listed.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection used dashboard and automated reports.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data were collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis was listed as annually with quarterly data collection.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel was provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were clearly presented.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement were documented in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data was included in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were directly related to barriers identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate for Baseline was 18%, which reduced to 16.2%, and further reduced to 15.5% for remeasurement 2 (ending June 2022). The goal was to reduce the rate to 15.5% and the goal was therefore met.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The improvement was related to the interventions although tracking will continue with a new goal rate of 15%.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis using chi square was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	Absolute Total Care
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2021
Review Performed:	2023

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS TECHNICAL SPECIFICATIONS MY2021

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Met**	Sampling was conducted according to specifications.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Met**	Replacements were conducted and found compliant.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION- ADULT
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The adult response rate was 10.3% (228 out of 2228) which is a decline from last year's rate of 12.1%. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022 ***Recommendation:*** *Consider additional oversampling as discussed during the onsite.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

CCME EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 7.8% (198 out of 2558) which is a decline from last year's rate of 9.4% (240 out of 2546 surveys). *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022 ***Recommendation:*** *Consider additional oversampling as discussed during the onsite.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

CCME EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD CCC
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 7.2% (118 out of 1650) which is a decline from last year's rate of 9.6% (158 out of 1646). The minimum number of completed surveys is less than the NCQA target of 411 surveys *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022 ***Recommendation:*** *Consider additional oversampling as discussed during the onsite.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Absolute Total Care
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CC.COMP.22, Policy Management, details Centene's departmental approach to the development and approval of policies and procedures by focusing on core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the						ATC's Organizational Charts clearly outlines the structure of each department. Onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						discussion addressed vacancies, name, and position clarification.
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					John McClellan is the President and CEO of ATC.
1.2 Chief Financial Officer (CFO);	X					Stephen Moore is the Chief Financial Officer.
1.3 * Contract Account Manager;	X					Melissa Luciano is ATC's Contract Account Manager.
1.4 Information Systems Personnel;						Brian LeClaire oversees the remote IT staff in South Carolina.
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Director of Utilization Management is Natalie Crumpton.
1.5.1 Pharmacy Director,	X					
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					Lee Jernigan is the Director of Case Management.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Vice President of Quality Improvement is Sharon Mancuso.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					SaBrina Macon is the Director of Provider Relations.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Barry Lewis is the Chief Medical Director.
1.10 *Compliance Officer;	X					
1.10.1 *Program Integrity Coordinator;	X					
1.10.2 Compliance/ Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					Quinn Henderson is the legal point of contact for ATC.
1.13 *Behavioral Health Director;	X					Frank Shelp is ATC's Board-Certified Psychiatrist.
1.14 *Program Integrity FWA Investigative/Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					SCDHHS requires MCOs to pay 90% of claims in 30 days and 99% of claims within 90 days. ATC did not provide specific statistics about the timeliness of its claims processing; the documentation provided states that it meets the State's claims processing requirements and sets that requirement as its processing goal. ATC recently had an independent audit performed by KPMG to review the effectiveness of their claims systems. The audit report found claims processing systems to meet the SCDHHS contractual obligations.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ATC's systems are capable of accepting and generating HIPAA compliant electronic transactions. Additionally, paper claims that are received are optically scanned and electronically stored in a HIPAA compliant Electronic Data Interchange (EDI) format.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					ATC utilizes a number of electronic tools to process and capture claims and member data. The MCO uses it's "Unified Member View (UMV)" application as a member data warehouse to capture demographics, member preferences, and attributes (such as third-party liability or special needs).
4. The MCO's management information system is sufficient to support data reporting to the State and	X					All claim and member data for HEDIS reporting are loaded from ATC's electronic data

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
internally for MCO quality improvement and utilization monitoring activities.						warehouse into the Catalyst Quality Spectrum Insight application. Catalyst Quality Spectrum Insight is a National Committee for Quality Assurance (NCQA) certified application designed to measure and report HEDIS data.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC provided its policy for managing and maintaining data security. The policy adheres to industry best practices and meets SCDHHS contract requirements. The policy is frequently reviewed and is overseen by the organization's Chief Security Risk Officer. Additionally, the MCO contracted with auditors to review the effectiveness of its overall security controls. The audit report concluded that security controls effectively met the organization's requirements and contractual obligations.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Similar to data security, ATC provided its policy for managing and maintaining system security. The policy adheres to industry best practices and meets SCDHHS contract requirements. The policy is frequently reviewed and is overseen by the organization's Chief Security Risk Officer. Additionally, the MCO contracted with auditors to review the effectiveness of its overall security controls. The audit report concluded that security controls effectively met the organization's requirements and contractual obligations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					ATC has a robust disaster recovery (DR) and/or business continuity plan for its information systems. The plan includes measures to mitigate system outages and data loss, and to fully failover to an alternate location if there is a data center outage. To ensure the effectiveness of its DR plan, the MCO conducts multiple recovery tests throughout the year. It's latest round of testing resulted in all recover time objectives and recovery point objectives being met.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The 2022 Compliance Plan Matrix and Attachments provided details about ATC's Compliance Program and applicable federal and state laws, regulations, accreditation standards, and contractual obligations.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					The 2022/2023 Compliance and Ethics Program Description details that ATC has established policies and procedures to maintain a Compliance Program that conforms to the Compliance Program Guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services, and includes the elements described in the Federal Sentencing Guidelines.
2.1 Standards of conduct;						The Business Ethics and Code of Conduct describes how ATC conducts business affairs in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						accordance with the standards and rules of ethical business conduct and to abide by applicable laws. All directors, officers, and employees are expected to comply with the standards contained in the Code of Conduct, immediately report any perceived violations, and assist in investigating any allegations of wrongdoing. This is also part of the new hire training agenda with annual retraining.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						ATC's VP of Compliance is considered the organization's Compliance Officer. Roles and responsibilities for the Compliance Officer are outlined in the Compliance Committee Charter along with contact information in the Employee Handbook.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Compliance Committee Charter identifies ways that the Compliance Committee assists the Compliance Officer in fulfilling oversight responsibilities and provide guidance in adopting and implementing an effective compliance program.
2.5 Compliance training and education;						Policy CC.COMP.10 Annual Compliance Training, outlines the required compliance training.
2.6 Lines of communication;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						
2.9 Response to offenses and corrective action;						
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
I E. Confidentiality *42 CFR § 438.224*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Confidentiality is clearly and consistently addressed in Policy CC.COMP.PRVC.01, Privacy Program Description, the Centene Employee Handbook, and in the Compliance Plan Matrix. The Compliance Department conducts trainings for new employees and annually, thereafter covering Centene's expectations regarding confidentiality and the handling of Protected Health Information.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a	X					The Centene Corporation Credentialing Program Description provides a brief overview of the Credentialing Program. Specific processes and requirements are detailed in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
manner consistent with contractual requirements.						Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. Policy CC.CRED.01 indicates ATC will process credentialing applications within 60 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments. However, Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational providers. Onsite discussion confirmed the timeframe of 60 calendar days is followed for processing organizational provider credentialing applications. Also, Policy CC.CRED.01 defines circumstances under which a practitioner may appeal the denial of a credentialing application. Corresponding information was not noted in Policy CC.CRED.09. Onsite discussion confirmed that there are circumstances under which an organizational provider may request reconsideration of the denial of credentialing into the network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers, and to include information about the availability for reconsideration of a denial of a credentialing application.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.		X				ATC's Medical Director is responsible for oversight of credentialing functions and serves as Chair of the Credentialing Committee. The Credentialing Committee meets monthly and reports to the Quality Improvement Committee (QIC). Policy CC.CRED.03, Credentialing Committee, describes the structure and processes used to make recommendations regarding credentialing decisions. The policy specifies that a quorum is established with the presence of at least two thirds of the voting members. The committee minutes confirmed the presence of a quorum at each meeting. The Credentialing Committee Charter, found on page 13 of the 2022 Quality Program Description, states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider. During

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						onsite discussion of this finding, ATC staff reported that non-participating providers may serve as members of the Credentialing Committee. This is not in compliance with footnote number 5 on page 3 of Policy CC.CRED.03, Credentialing Committee, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers." *Quality Improvement Plan: To comply with requirements of Policy CC.CRED.03, Credentialing Committee, replace the non-participating practitioner member of the Credentialing Committee with a network practitioner.* When reviewing Credentialing Committee minutes, documentation of member attendance was unclear. For example, for the November 8, 2022, Credentialing Committee meeting, one practitioner with designated with the letter "E." When questioning health plan staff about the meaning of this designation, it was first reported that it signified an excused absence; however, staff then reported it signified that attendance/voting for the practitioner was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						done by email. CCME confirmed that an "X" indicates the committee member was present for the meeting, and a dash ("-") indicates the committee member was absent. However, one practitioner was designated as absent from February 2022 through November 2022. Onsite discussion revealed the practitioner was not a member of the committee after January 2022. *Recommendation: Add a key to the Credentialing Committee minutes to define the indicators used to indicate attendance. Ensure former committee members are designated as such on the minutes.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					ATC's Quality Improvement and Credentialing programs monitor the quality and safety of practitioner services, and the Credentialing Committee makes decisions about provider suspensions, restrictions, or terminations after investigations are conducted. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, describes health plan processes for taking disciplinary action against

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a provider (including administrative suspension, administrative termination, summary suspension and termination), reporting to the National Practitioner Data Bank, and transitioning members to alternate providers.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					One file for a Rural Health Clinic (RHC) did not include a DHEC license. A copy of this RHC's DHEC license was requested, and after the onsite, ATC responded that the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7*, has been revised to remove the requirement for Rural Health Clinics to be surveyed and licensed by DHEC. However, this requirement is still noted in ATC's Policy CC.CRED.09, Attachment M, item 10, which states, "Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS." *Recommendation: Revise Policy CC.CRED.09, Attachment M, to remove the requirement that RHCs must be surveyed and licensed by DHEC if the plan is not operating under this requirement.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, defines ATC's processes for ongoing monitoring of network

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers for sanctions and exclusions to ensure that no payments are made to individual providers or entities who are excluded from participation in any federal health care program. This activity is conducted by Credentialing staff and queries include NPDB reports, the OIG LEIE, state licensing boards, SAM, state exclusion lists, etc.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC evaluates access to PCPs at least annually. This assessment includes the number and geographic distribution of PCPs compared to the standards defined by SCDHHS. ATC defines PCPs as family/general practitioners, internists, and pediatricians. Data sources used when conducting the evaluation include Geo Access mapping, network adequacy reports, and member grievances related to practitioner access. The evaluation also includes an analysis of causes for any

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified deficiencies, including barriers, opportunities for improvement, and prioritization of those opportunities. Interventions are developed and implemented as needed. The 2022 Medicaid Network Analysis document dated November 4, 2022, indicates the parameter used for PCP provider types is 1 provider within 30 miles. The 2021 Quality Improvement Program Evaluation lists the access parameter for PCPs as one provider within 45 minutes or 30 miles of the member's home.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC evaluates access to specialists, including the number and geographic distribution against standards defined by SCDHHS, at least annually. Data sources used to conduct the evaluation include Geo Access mapping, network adequacy reports, member grievances related to practitioner access, etc. The evaluation also includes an analysis of causes of identified deficiencies, barriers, opportunities for improvement, and prioritization of those opportunities. Interventions are developed and implemented as needed. The 2022 Medicaid Network Analysis document, dated November 4, 2022, indicates the parameter

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						used for specialty providers is 1 provider within 50 miles; however, each specialty is listed with the average distance to the 1st through 5th closest provider. The 2021 Quality Improvement Program Evaluation lists the access parameter for specialists as one provider within 50 miles or 75 minutes miles of the member's home.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					ATC assesses its membership's cultural, ethnic, racial, and linguistic needs annually and collects related practitioner cultural, ethnic, racial, and linguistic data on a voluntary basis through credentialing processes. ATC uses the results of these activities to make network adjustments as needed. In addition, data from member satisfaction surveys and grievances are monitored to identify areas for possible improvement. Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), provides detailed information about processes and activities to ensure members are provided with cultural and linguistic services as contractually required and in compliance with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and the Affordable Care Act. The policy covers activities related to health literacy and plain communication, language services, reducing health disparities, cultural competency, and supporting members with disabilities. The Provider Manual includes an overview of Cultural Competency and health plan activities and refers readers to the website for more information about ATC's Cultural Competency and Linguistically Appropriate Services (CCLAS) Program. ATC's website allows providers to download copies of the following: • 2022 CCLAS Program Description • Americans with Disabilities Act (ADA) – Disability Awareness Quick Reference Guide • Cultural Competency Quick Reference Guide The website also links providers to "A Physician's Practical Guide to Culturally Competent Care," which is an online, accredited program that provides continuing education credits for physicians, physicians assistants, and nurse practitioners; although other interested parties may take the course.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					When network gaps are identified, ATC takes action to address areas of concern. The Absolute Total Care (ATC) Network Strategy Overview January 2023 document indicates ATC expanded its network beginning in 2022 and continues to add providers. For the Medicaid network, ATC has been focusing on the key areas of pediatrics and obstetrics/gynecology. The MCO also is working to engage with non-contracted, independent, free standing ambulatory surgery centers throughout the state to increase access at lower costs. ATC has also increased the number of contracting nursing homes in the state to improve member access. The Network Strategy Overview document shows there are many ongoing initiatives to expand and improve ATC's network.
2. The MCO maintains a provider directory that includes all requirements.	X					Policy CC.PRVR.19, Provider Directory – Portico, states ATC maintains a searchable, printable, web-based Provider Directory that includes all network providers. The policy lists elements that must be included in the Provider Directory and details processes for maintaining provider information for inclusion in the directory. Review of the web-based

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Directory confirmed all required elements are included.
3. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy CC.PRVR.48, Evaluation of the Accessibility of Services, states ATC evaluates appointment accessibility to PCPs, BH providers, and specialists annually. Resulting data is analyzed and recommendation for addressing any identified deficiencies are developed as needed. Appointment access standards are appropriately documented across Policy CC.PRVR.48, the Provider Manual, and the Member Handbook.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the annual EQR process for ATC, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by ATC, within which a population of 2,291 unique PCPs was found. A sample of 190 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by CCME, calls were successfully

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						answered 61% of the time (105 out of 190) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's result of 61%, this year's study had no change in successful calls at 61% (p=.977). For those not answered successfully (n= 67 calls), 34 (51%) were because the provider was no longer an active PCP at that location. For the question "Do you accept Absolute Total Care?" 95 out of 105 (90%) said that they do accept ATC. Of those 95, 59 (62%) providers were accepting new Medicaid patients; 27 out of those 59 (46%) indicated they do have prescreening requirements. Of those 27 providers with prescreen requirements, 8 (30%) required an application, 15 (56%) required a medical record review, three (11%) required both, and one (4%) required both and vaccine records. *Recommendation: Continue current interventions and seek additional options to effect improvement in successful contacts for Provider Access Call Studies.*
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					As noted in Policy SC.PRVR.13, Provider Orientations, new provider education is provided within 30 business days of the contract effective date for all newly contracted providers who are not part of an established network group or facility. The education sessions are coordinated by Provider/Network Relations, and attendance records are maintained. The 2021 Medicaid provider orientation PowerPoint document includes an overview of Centene and addresses the role of Provider Network Specialists, provider responsibilities, verifying member eligibility, member ID cards, utilization management processes, claims submission/disputes/appeals, fraud/waste/abuse, web based provider tools, etc.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					The Provider Manual covers general billing guidelines, claims submission, claim adjustments, provider disputes, code auditing and edits, billing codes and forms, third party liability, member billing, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					The Provider Manual addresses covered services, benefit limitations, non-covered services, and enhanced member benefits. A "Member Benefit Grid and Copays" table is included in the Provider Manual.
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					Providers are informed via the Provider Manual of responsibilities for providing 24 hour coverage and an after-hours telephone number. The Provider Manual also includes appointment access standards for PCPs, specialists, and behavioral health providers.
2.6 Recommended standards of care;	X					The Provider Manual includes information about preventive health and clinical practice guidelines and protocols. ATC encourages providers to use guidelines as a basis for member treatment plans and as an aid for members to make healthcare decisions. Lists of currently adopted preventive health and clinical practice guidelines are included in the manual, and providers are directed to the website for additional information.
2.7 Medical record handling, availability, retention and confidentiality;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing provider education is accomplished through regularly scheduled meetings with Provider/Network Relations Specialists. Facility education is provided through quarterly Joint Operations Committee (JOC) meetings. In addition, quarterly regional provider training sessions are held virtually. Providers are informed of changes to the program, policies, procedures, and requirements through Provider Manual Updates, newsletters, the website, etc.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national	X					Policy SC.QI.08, Clinical and Preventive Practice Guidelines, describes ATC's process

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
standards and covered benefits and that are periodically reviewed and/or updated.						for reviewing and adopting preventive health guidelines (PHGs) and disseminating them to providers. Through its Quality Improvement Committee (QIC), ATC adopts PHGs that are pertinent to its member population and that are originated from recognized sources. ATC reviews the guidelines annually and updates the guidelines based on significant new scientific evidence and/or changes in national standards. The PHGs include guidelines for all age ranges.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					As noted in Policy SC.QI.08, the PHGs are disseminated to practitioners based on specialty and upon request. New and revised guidelines are posted to ATC's website and may also be disseminated via provider orientation materials, newsletters, fax, and special mailings. The Provider Manual informs that provider compliance with the guidelines may be monitored through HEDIS measures and/or medical record audits.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Following the process above for PHGs, ATC also adopts clinical practice guidelines (CPGs) for acute and chronic medical conditions and behavioral health conditions which are relevant to the membership.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					As noted in Policy SC.QI.08, the guidelines are disseminated to practitioners based on specialty and to members and other providers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						upon request. New and revised guidelines are posted to ATC's website. New and revised guidelines may also be disseminated via provider orientation materials, newsletters, fax, and special mailings. The Provider Manual informs that provider compliance with the guidelines may be monitored through HEDIS measures and/or medical record audits.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Processes for monitoring and evaluating continuity and coordination of care are detailed in Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care. The QI Program Description states, "ATC monitors and takes action as needed to improve continuity and coordination of care across the health care network. This includes continuity and coordination of medical care through collection of data on member movement between practitioners and data on member movement across settings. Continuity and coordination between medical care and behavioral healthcare is also monitored with data collected in several areas to identify opportunities for collaboration. ATC collaborates with behavioral healthcare

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						practitioners to complete analysis of the data collected in the areas noted above and identify opportunities for improvement. Continuity and coordination of medical care, and between medical care and behavioral healthcare, may be assessed via several different measures or activities. These include but are not limited to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc. ATC collects data related to continuity and coordination of care, analyzes the data to identify opportunities for improvement, selects opportunities for improvement, and implements actions for improvement. The effectiveness of improvement actions is measured annually and re-measurement results analyzed." The 2021 QI Program Evaluation includes an overview of continuity and coordination of care activities conducted, along with an assessment of the effectiveness of interventions, barriers, opportunities for improvement, and an action plan with prioritization and implementation dates.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Processes for assessing provider compliance to medical record documentation standards are detailed in Policy SC.QI.13, Medical Record Review. Specific medical record documentation requirements are included in Attachment A of this policy, in the Provider Manual, and on ATC's website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Standards for medical record documentation are appropriately documented across Attachment A of Policy SC.QI.13, the Provider Manual, and on ATC's website.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Providers are educated via the Provider Manual about medical documentation and maintenance requirements. ATC conducts an annual medical record audit for PCPs (and may include high volume specialists) to evaluate provider compliance with medical record requirements. Audits are conducted by qualified health plan or vendor staff who have signed confidentiality agreements. Providers are expected to score 80% or more for the audit. Providers with scores below 80% are notified of deficiencies and actions required to address the deficiencies. A follow-up audit will be conducted within 6 months. Providers who continue to fall below the established scoring requirement are discussed with the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medical Director and the VP of Contracting/Network Management for further action. This may result in additional medical record review by the Medical Director, referral to the QIC and/or Peer Review Committee, or termination of network participation. An audit summary is presented to the QIC annually and results are trended by the Quality Department to identify opportunities for improvement. Minutes from the 5/31/22 QIC Meeting stated, "Sixty-nine (69) practitioners' medical records were audited with an overall score of 96.4%. There were no practitioners who scored below the required minimum score of 80%. Practitioners or practices whose overall audit score is above 80% require no follow-up action by the practitioner or the plan."
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy SC.MBRS.25, Member Rights and Responsibilities, defines how ATC advises members of their rights and responsibilities and how these rights are protected.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy SC.MBRS.25, Member Rights and Responsibilities, describes how member rights are protected.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						Copayments and limits of coverage are listed in the Member Handbook and on the website.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. Prior approval is not required for family planning services, emergency visits, or behavioral health services.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The nurse advice line is available 24-hours a day, seven days a week. Medical advice for children and adults, health information, assistance in determining where to go for care, answers to personal health questions, and information about pregnancy are available by calling the nurse advice line.
1.7 Policies and procedures for accessing specialty care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook and ATC's website indicate that durable medical equipment and medications are covered and may require prior authorization in some instances.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						The steps for filing a grievance are detailed in the Member Handbook and on ATC's website.
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The steps for requesting assistance with interpretation services or materials in languages other than English are outlined in the Member Handbook, the ATC website, the Welcome Packet, and in various letter templates available to members.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						Policy SC.QI.25, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description, describes ATCs work to ensure that members, through the month of their 21st birthday, receive comprehensive and preventive health care and services based upon adopted practice guidelines.
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						The Member Handbook and ATC's website provide information about advanced directives. Information is provided about points of contact for assistance if member's directives are not followed.
1.21 Information on how to report suspected fraud or abuse;						Fraud and abuse are defined in the Member Handbook and on ATC's website. Examples and instructions are provided for members to anonymously report fraud and abuse to ATC and to SCDHHS' Division of Program Integrity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy SC.ELIG.17, Enrollment, describes that the member enrollment process begins by obtaining a Primary Care Provider. The member listing will provide the data for the New Member Welcome Letter, the New Member Welcome Call and the New Member Welcome Packets.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Information on member disenrollment is provided in Policy SC.ELIG.10, Member Disenrollment, the Member Handbook, and on ATC's website. All Member requests for disenrollment are referred to SCDHHS or its designee. Effective date of an approved disenrollment request must be no later than the first day of the second month following the month in which the Medicaid Member filed the request.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					ATC contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the adult and child satisfaction surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					SPH analytics summarizes and details all results from the Child, CCC, and Adult surveys.
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH analytics summarizes and details all results from the surveys.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Results of the CAHPS surveys were reported and discussed during the August 2022 QIC meeting.
4. The MCO reports the results of the member satisfaction survey to providers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Issues and action plans were reported in the QIC meetings and in the 2022 CAHPS Intervention File.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC.MM.11, Member Grievances, the Member Handbook, and ATC's website clearly address the grievance processes and procedures.
1.1 The definition of a grievance and who may file a grievance;	X					Per ATC policy and other materials, a grievance may be filed for dissatisfaction about any matter other than an adverse benefit determination. A grievance may be filed at any time. Grievances may be filed by the member or member's authorized representative with ATC either orally or in writing.
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy SC.MM.11, Member Grievances, states that grievances will be acknowledged via letter within 5 calendar days of receipt of a grievance. Grievances will be resolved as expeditiously as the member's physical or mental health condition requires. Clinically Urgent Grievances will be resolved within 72 hours from the day ATC receives the grievance. Standard Grievances resolution may not exceed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						90 calendar days from the day ATC receives the grievances.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Grievance records are maintained in a manner accessible to the state and available upon request to CMS per Policy SC.MM.11, Member Grievances.
2. The MCO applies grievance policies and procedures as formulated.	X					The 2022 grievance files reviewed found that all met timeliness standards specific to the acknowledgement and letters of resolution. Explanations were discussed for two files onsite.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC.MM.11, Member Grievances, indicates that member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. ATC tracks and monitors member grievance data quarterly. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					ATC provided the 2022 Quality Improvement Program Description for this EQR. This program description provides an overview of the QI Program that ATC has established to improve the quality of care delivered to their members. The QI Program Description included the program's structure, goals, scope, and methodology. Members and providers are provided information regarding the QI Program on ATC's website, in the Member Handbook and Provider Manual.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually ATC develops a work plan to help manage workflow, assign tasks, and track various components of the QI Program. The 2021 and 2022 Work Plans included the scope, activity description and objectives, responsible party, timeline, and the status for each activity. During the previous EQR, CCME recommended that ATC include the oversight monitoring of all functions performed by a delegated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						entity in the QI work plan. ATC included this recommendation in the QI Work Plan and added the oversight monitoring of the delegated entities.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					ATC's Board of Directors delegates the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC is the senior management lead committee responsible for reporting the program's activities, findings, recommendations, actions, and results to the Board at least annually. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved.
2. The composition of the QI Committee reflects the membership required by the contract.	X					ATC's Chief Medical Director chairs the QIC. Voting members for this committee include ATC's senior leaders and network practitioners specializing in Family Medicine, OB/GYN, Pediatrics, and Psychiatry. A quorum is defined as a minimum of three committee members including the committee chair, one health plan staff and one external practitioner. The minutes submitted for this EQR demonstrated the presence of a quorum for each meeting.
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					The QIC Charter indicates meeting minutes will reflect the committee's decisions, actions, follow-up or next steps, and subcommittee reports. Per the charter, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						minutes are completed no later than 30 days after the meeting. The minutes are reviewed and approved at the next regularly scheduled meeting. For this EQR, minutes were provided for meetings held from December 2021 through December 2022.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. The Persistence of Beta Blocker Treatment After a Heart Attack showed a 10.18% increase. There were no rates that showed a substantial decrease.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					ATC submitted two PIPs for validation. Topics for the PIPs included Adult Access to Preventive Health Care and Hospital Readmissions.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					ATC requires all network providers to comply with the requirements outlined in the provider agreement that includes the participation with quality assessment and improvement activities. A sample provider agreement was provided that outlined these requirements. Network providers are also encouraged to participate through committees that play an active role in the directions and specific initiatives. ATC's website provides a brief summary of the QI Program with some HEDIS and CAHPS comparative results.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					ATC's network providers receive feedback regarding their performance data through the Provider Analytics, Interpreta, and Physician Report Cards. Provider Analytics is a quality, cost, and utilization tool designed to support providers who participate in a value-based program. This tool helps providers identify where to focus clinical efforts. Interpreta is an analytic tool available to providers for generating member care gap reports. ATC also generates a Physician Report Card annually and shares the results with high-volume pediatricians. The report card is based on specific HEDIS measures and compares their rates with ATC's overall Health Plan rates. The current provider performance metrics are Well-Child visits in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the first 15 months of life, Well-Child visits for ages 15 to 30 months, and Child and Adolescent Well Care visits.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, ATC assesses the effectiveness of the QI Program and documents that assessment in the QI Program Evaluation. The 2021 Quality Improvement Program Evaluation reviewed for this EQR included the results of activities and studies underway or completed in 2021. A barrier analysis and any recommendations for 2022 to overcome those barriers were also included. The evaluation was submitted to the QIC in May 2022 and approved with no further recommendations.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					ATC's Utilization Management (UM) Program Description outlines staff responsibilities, scope, and objectives for physical health and behavioral health services. ATC's pharmacy program is integrated into the UM program to ensure access and manage pharmacy authorizations. Centene Pharmacy Solutions is the current pharmacy benefit manager. Additionally, the UM, Case Management, Disease Management, Pharmacy and Therapeutics (P&T), Quality Improvement (QI), Credentialing, and Fraud and Abuse Programs are closely linked in function and process.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					There are various guidelines and evidenced based clinical criteria that ATC's staff use to make clinical determinations, such as InterQual, American Society

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of Addiction Medicine (ASAM), etc., to determine medical necessity and appropriateness of care.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Policy SC.UM.54, Preferred Provider Designation, outlines the preferred provider designation policy that allows providers to become a preferred provider based upon various quality and practice guideline qualifications. This Preferred Provider Designation allows for the preferred providers to be exempt from prior authorizations and to receive eligibility for expedited prior authorization requests. This status is reviewed annually, can be revoked at any time, and is subjected to retrospective review. There are currently three preferred providers within the network.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					ATC's UM Program Description, Centene Advanced Behavioral Health UM Program Description, and the Pharmacy Program Description provide a descriptive overview of the roles and responsibilities of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medical Director, Behavioral Health Director, and Pharmacy Director. The Medical Director is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews. A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of ATC's UM program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					As described in Policy CC.UM.02.01, Medical Necessity Review, and in the program descriptions, ATC utilizes evidenced based criteria such as InterQual, American Society of Addiction Medicine (ASAM), etc. in conjunction with individual clinical care needs of a member to determine medical necessity. Also, no preauthorization is required for members to receive emergency services as described in Policy SC.UM.12, Emergency Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The approval files reviewed during this EQR reflected that review staff used appropriate criteria when making clinical determinations. Additionally, the clinical determinations were completed within the required contractual guidelines for standard and expedited requests.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					ATC conducts annual Inter-Rater Reliability (IRR) testing for physicians and UM reviewers. IRR testing includes several domains such as acute/adult pediatric care, inpatient rehabilitation, durable medical equipment, long term acute care, etc. The overall result of the Medical IRR testing domains generated an average score of 94%, exceeding the goal of 90%. Additionally, Behavioral Health IRR testing results yielded an average score of 98%. This exceeded the previously stated goal of 90%.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC.UM.12, Emergency Services, the Member Handbook, and the Provider Manual provide a detailed overview of the emergency and post stabilization process. No prior authorization is required for emergency services.
8. Utilization management standards/criteria are available to providers.	X					Providers may contact the Provider Services Department to obtain clinical coverage policies. Additionally, the Provider Manual explains that criteria may be provided by contacting the UM Department.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the approval files reflected that determinations were completed within 14 calendar days for standard requests and 72 hours for urgent requests.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files reflected that additional clinical information is requested prior to making an adverse benefit determination. However, there was one file wherein the additional information was requested by the UM Reviewer after completion of the denial decision.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of the denial decisions demonstrated that adverse benefit determinations were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. There were two denial files wherein the adverse benefit determination notices incorrectly informed the member that a written appeal is required within 14 days of an oral request. This is no longer a contractual requirement. During onsite discussion, ATC reported they had already identified this as a concern and found there were two different versions of the adverse benefit determination notice in the system. The appeals review team was not consistent in utilizing the updated version of the notice. It was reported that this error was corrected in the Spring of 2022 and the old letter templates were removed from the system. *Recommendation: Re-educate staff regarding the new adverse benefit notifications.*
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC.MM.13, Member Appeals, the UM Program Description, Provider Manual, and the Member Handbook outline ATC's appeals process.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The terms "adverse benefit determination" and "appeal" were appropriately defined and information that a member or a member's authorized representative, acting on their behalf, may file an appeal were included in Policy SC.MM.13, Member Appeals.
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of the appeal files reflected that the appeal guidelines and processes were followed according to contractual standards.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Quarterly, a summary of member appeals is reviewed by the Utilization Management Committee to identify trends and opportunities to improve quality of care and services. Review of the meeting minutes from November 2021 through November 2022 confirmed an evaluation and analysis summary of appeals was presented to the committee. Additionally, a discussion of strengths and opportunities for improvement was presented.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					A descriptive overview and the approach of ATC's Care Management Programs are outlined in Policy CC.CM.01, Care Management Program Description, Policy CC.CM.02, Care Coordination/Care Management Services, the Population Health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Management Strategy document, Policy SC.UM.41, Transition of Care, and Program Description.
2. The MCO has processes to identify members who may benefit from care management.	X					ATC members are referred for care management services through various sources, such as provider referrals, vendor referrals, self-referrals, department referrals, delegated entities, and many other referral sources. Additionally, direct referrals are considered high priority referrals for care management services as identified in Policy CC.CM.01, Care Management Program Description.
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					Policy CC.MM.01, Care Management Program Description Addendum, Policy CC.CM.02, Care Coordination Care Management Services, and Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Healthcare, provide an overview of processes and guidelines for care management activities for members receiving behavioral health services. It was described that if the member's primary diagnosis is a behavioral health condition, then the behavioral health care manager is the primary contact. Likewise, if a member presents with multiple behavioral and medical co-morbidities, the primary care manager is assigned based upon the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member's presenting primary needs. However, despite who the primary assigned care manager is, the team provides an integrated approach to manage the member's needs.
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					As described in Policy CC.CM.08, Care Management Member Satisfaction Survey, ATC conducts member satisfaction surveys monthly. These surveys are completed telephonically or by email with members who have been enrolled in the Care Management Program for at least 30 days. The surveys assess the effectiveness of the program addressing the cultural needs, barriers, etc. for members. This aids in identifying barriers and prompt individual care management feedback and training if needed. Additionally, a qualitative analysis is conducted to identify any trends and opportunities for improvement.
8. Care management and coordination activities are conducted as required.	X					ATC's care management files indicated care management activities are conducted as required.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					As noted in Policy SC.UM.18, Oversight of Delegated Utilization Management, and Policy CC.CRED.12, Oversight of Delegated Credentialing, ATC evaluates potential delegates prior to enacting a delegation agreement to ensure the entity can conduct the delegated activities in compliance with health plan

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standards and requirements, as well as in compliance with requirements of the *SCDHHS Contract*, NCQA, and other requirements. Overall processes for initial delegation and ongoing monitoring and evaluation of delegate performance are found in these policies. The policies note that ATC retains accountability for services that are delegated to external entities.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				No annual oversight documentation was submitted for Envolve People Care Behavioral Health. During onsite discussion, ATC staff stated that an annual evaluation was conducted in 2022, but that delegation would not continue for this delegate in 2023. ATC confirmed they would submit evidence of the 2022 annual evaluation; however, no documentation was received. ATC's documentation reflects that this delegate conducts behavioral health service authorizations and medical necessity denials, along with associated member and provider notice of adverse benefit determination letters, and provider generated complaints. Documentation of annual oversight for the remaining delegates included appropriate audit and file review tools, and documentation of results, recommendations, and any needed corrective actions. Policy CC.CRED.12, Oversight of Delegated Credentialing, states the plan monitors delegate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance in a variety of ways, including by conducting at least annual evaluations to assess performance. • Section III (C) of the policy states summaries of routine oversight meetings and evaluation of interim reporting are presented at the next regularly scheduled Credentialing and/or QIC for review and approval. • Section IV (E) states a summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities and presented to the Credentialing and/or QIC for review and approval. • Section V (E) states reports about any ongoing corrective action plans will be presented to Plan Credentialing/QIC at least quarterly. During onsite discussion with staff responsible for delegation oversight activities, it was confirmed that annual oversight evaluations are conducted by corporate staff, and that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). Review and discussion of the reports of non-credentialing delegation were clearly noted in the QIC minutes submitted for review. However, the Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight, specifically the items specified in Policy CC.CRED.12 (noted above). During onsite discussion,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						it was reported that the Credentialing Committee minutes submitted for review were the final minutes. Binders attached to the QIC minutes included copies of Credentialing Committee minutes; however, discrepancies were noted for two sets of minutes when compared to the submitted minutes. After completion of the onsite review, a statement was received from ATC/Centene staff that the originally submitted minutes were not final. Further, the 2021 QI Program Evaluation, page 117, indicates that for all Credentialing delegates, the Credentialing Committee reviewed the results of credentialing delegate audits during the February 8, 2022 meeting. Upon re-examination of the originally submitted Credentialing Committee minutes, as well as the minutes attached to the QIC binders, there was no evidence identified to support this. *Quality Improvement Plan: Ensure annual evaluations are conducted for each delegated entity. To comply with requirements of Policy CC.CRED.12, Oversight of Delegated Credentialing, implement actions to ensure that either the QIC or Credentialing Committee receives and reviews summaries of routine oversight meetings, evaluations of interim reporting, a summary of the annual delegation review via the Report of*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Delegation Oversight Activities, and reports about any ongoing corrective action plans.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					ATC requires applicable providers to administer appropriate vaccinations during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits and encourages providers to enroll into the Vaccines for Children (VFC) program. To support this, ATC educates providers about EPSDTs/vaccinations and related documentation requirements. Provider compliance with immunization administration requirements is evaluated through annual medical record audits and by monitoring HEDIS reporting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 performing EPSDTs/Well Care.	X					ATC's EPSDT Program requires providers to perform EPSDT medical check-ups in their entirety at intervals required by the adopted AAP / Bright Futures Recommendations for Preventive Pediatric Health Care. Providers are expected to document all EPSDT exam elements in the member's medical record. ATC educates providers about the EPSDT Program and related documentation requirements and disseminates lists of noncompliant members and members with care gaps. Provider compliance with provision of EPSDT services is evaluated through annual medical record audits and by monitoring HEDIS reporting. Medical record review results are filed in the QI department and shared with the Credentialing department to be considered at the time of recredentialing.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					